

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  |   |  |   |  |  |  |
|--|--|---|--|---|--|---|--|--|--|
| 1. FOR<br>STATE<br>REGISTRAR   |  |   | REG. NO.   |   |  |   |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  |   | 2a. DATE OF DEATH  |   |  | 2b. HOUR  |  |  |  |
| HENRY DAVID MacCOOL  |  |   | 2. MONTH DAY YEAR<br>2 4 82  |   |  | 11 30 AM  |  |  |  |
| 3. SEX   |  | 4. RACE   |  | 5. DATE OF BIRTH  |  | 6. AGE (IN YEARS LAST BIRTHDAY)                                     |  | 7. IF UNDER 1 YEAR   |  |
| MALE   |  | WHITE   |  | 2/13/1913   |  | 68 YRS.   |  | MONTHS DAYS HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY?  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |  |  |  |
| PHILA., PENNA.   |  | U.S.A.  |  |   |  | BALTO. CITY MD.   |  |  |  |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)    |  | 12b. KIND OF BUSINESS OR INDUSTRY                              |  |
| BALTIMORE  |  | UNIONMEMORIAL HOSPITAL  |  |   |  | MILL REP.   |  | BOARD MGR.   |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |   |  |   | 13b. INSIDE CITY LIMITS?   |   | 13c. STREET ADDRESS  |  |  |
| 13a. STATE COUNTY BALTO.   |  |   |  |   | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |   | 3 DUNKIRK RD. 21212  |  |  |
| 14. FATHER'S NAME  |  |   |  |   | 15. MOTHER'S MAIDEN NAME   |   |  |  |  |
| 14. FIRST MIDDLE LAST<br>JOHN NICHOLAS MacCOOL   |  |   |  |   | 15. FIRST MIDDLE LAST<br>LILLIAN ALLEN MOSS  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)   |  |   |  |   | 16b. SOCIAL SECURITY NO.   |   | 17. INFORMANT ADDRESS                                      |  |  |
| NO   |  |   |  |   | 196.07.2755  |   | ROBERT A. MacCOOL 110 W. 39TH. ST.<br>BALTIMORE, MD. 21210 |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Admission unknown primary</u><br><u>1991</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Metabolic disease w/ brain</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u></u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. |  |   |  |   |  |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>none</u>   |  |   |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |  | 20a. AUTOPSY?   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |  |
|  |  |   |  |   |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | YES <input type="checkbox"/> NO <input type="checkbox"/>       |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>2/4/82</u> , 19 <u>82</u> , to <u>2/4/82</u> , 19 <u>82</u> , that (I) (we) lost saw the deceased alive on <u>2/4/82</u> , 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                       |  |   |  |   |  |   |  |  |  |
| 22b. SIGNATURE<br><u>John H. Epple, MD</u>   |  |   |  |   | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   | 22c. DATE SIGNED<br><u>2/4/82</u>                          |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>JOHN H EPPLE</u>   |  |   |  |   | 22e. ADDRESS<br><u>WMH</u>   |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)   |  |   | 23b. DATE  |   | 23c. NAME OF CEMETERY OR CREMATORY   |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE                 |  |  |
| CREMATION  |  |   | 2/5/1982   |   | GREEN MOUNT CREMATORY  |   | BALTIMORE MARYLAND   |  |  |
| 24. FUNERAL DIRECTOR<br>WALTER BROOKS BRADLEY INC., BALTO MD 21222   |  |   |  |   | 25a. DATE REC'D. BY REGISTRAR  |   | 25b. REGISTRAR'S SIGNATURE<br><u>Frances Jan Nathan</u>    |  |  |
|  |  |   |  |   | FEB 5 1982   |   |  |  |  |



UNITED STATES DEPARTMENT OF AGRICULTURE

WASHINGTON, D. C.

D

My dear Sir:



Very truly,  
Yours,  
[Signature]

[Signature]



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified for one.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |   |  |   |  |  |  |
|--|--|--|--|---|--|---|--|--|--|
| FOR<br>1 - STATE<br>REGISTRAR  |  | REG. NO. 8 2 0 3 9 8 3   |  |   |  |   |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>LEWIS N. MACCUBBIN  |  |  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>February 22, 1982 |   |  | 2b. HOUR<br>6:45 AM  |  |
| 3. SEX<br>Male   |  | 4. RACE<br>White   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>July 22, 1918   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>63 YRS.  |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD                                       |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Wyman Park Apts. #411                         |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>CPA                         |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Self-Employed   |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |  |  |   |  |   |  |  |  |
| 13a. STATE<br>Maryland   |  | 13b. COUNTY  |  | 13c. CITY OR TOWN<br>Baltimore  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br>3925 Beech Avenue 21211   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Frank Maccubbin  |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Lillian Long   |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>215 03 5346   |  | 17. INFORMANT<br>ADDRESS<br>Mrs. Dorothy S. Maccubbin, Same   |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Sudden Death</u><br>2500<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>ASCVD</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>Diabetes mellitus</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) |  |  |  |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>4 1/2 yrs<br>4 1/2 yrs   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |  |  |
| 22a. I certify that (I) (the hospital) attended the deceased from 2/11 1975 to 1/20 1982, that (I) (we) last saw the deceased alive on 1/20 1982, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (we do not) view the body after death.   |  |  |  |   |  |   |  |  |  |
| 22b. SIGNATURE<br><i>[Signature]</i>   |  | DEGREE<br>MD<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  |   |  | 22c. DATE SIGNED<br>2/22/82   |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Dr. Andrew P. Weinfeld, M.D.  |  | 22e. ADDRESS<br>222 W. Cold Spring Lane, Balto., Md.   |  |   |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial   |  | 23b. DATE<br>2/25/82   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Lorraine Park   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Balto., Md.                                       |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Henry W. Jenkins & Sons Co.<br>ADDRESS<br>4905 York Road Balto., Md. 21212   |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br>FEB 23 1982  |  | 25b. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>  |  |  |  |



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| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |   |   |   |  |   |  |  | REG. NO.  |  |
|--|--|---|---|---|---|--|---|--|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>ELLA A. MACHOVEC</b>   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>2 13 82</b> |   |   | 2b. HOUR<br>MIN.<br><b>5<sup>55</sup> AM</b>   |   |  |  |   |  |
| 3. SEX<br><b>Female</b>  |  | 4. RACE<br><b>White</b>   |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>July 29, 1906</b>  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>YRS.<br><b>75</b>                                 |   | IF UNDER 1 YEAR<br>MONTHS DAYS   |  | IF UNDER 24 HRS<br>HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>       |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City,</b> MD.                   |   |  |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Baltimore City Hospital</b> |   |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Housewife</b> |   | 12b. KIND OF BUSINESS OR INDUSTRY  |  |   |  |
| 13a. STATE<br><b>Maryland</b>  |  |   | 13b. COUNTY<br><b>Baltimore</b>                       |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>1301 Wohler Way</b> |  |  |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Frank Machovec</b>  |  |   |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Anna Unknown</b>                            |  |   |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>218-01-8243</b>  |   | 17. INFORMANT ADDRESS<br><b>Mrs. Frances D. Wolff 3711 Evergreen Ave/</b>   |   |  |   |  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Ventricular arrhythmia</b><br><b>5570</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>hypertension</b><br>DUE TO, OR AS A CONSEQUENCE OF<br><b>renal failure / sepsis</b> |  |   |   |   |   |  |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>40 min</b><br><b>40 min</b><br><b>days</b> |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):<br><b>Sepsis</b>  |  |   |   |   |   |  |   |  |  |   |  |
| 19a. DATE OF OPERATION<br><b>2/13/82</b>   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>large / small bowel neovosis</b>   |   |   |   | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |   |  |   |  |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |  |   |  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>2/1/82</b> , 19 <b>82</b> , to <b>2/13</b> , 19 <b>82</b> , that (I) (we) last saw the deceased alive on <b>2/13</b> , 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (d) (did not) see the body after death.  |  |   |   |   |   |  |   |  |  |   |  |
| 22b. SIGNATURE<br><b>KATHLEEN DBELSTED</b>   |  |   |   | DEGREE<br><b>MD</b><br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   |  |   | 22c. DATE SIGNED<br><b>2/13/82</b>   |  |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>KATHLEEN DBELSTED</b>  |  |   |   | 22e. ADDRESS<br><b>EASTERN AVENUE / BLIT BALTIMORE MD</b>   |   |  |   |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Cremation</b>  |  | 23b. DATE<br><b>Feb. 15, 1982</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Green Mount</b>  |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Maryland</b>              |   |  |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Leonard J. Ruck, Inc. Balto., Md.</b>   |  |   |   |   |   | 25a. DATE REC'D. BY REGISTRAR<br><b>FEB 16 1982</b>                                  |   | 25b. REGISTRAR'S SIGNATURE<br><b>Thomas J. Thistle</b>   |  |   |  |

SECRET

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 - 0 3 2 8 5

1- FOR  
STATE  
REGISTRAR

REG. NO.

|  |   |  |   |  |  |
|--|---|--|---|--|--|
| 1 DECEASED NAME<br>(TYPE OR PRINT)<br>JOHN WILLIE (MAY) MAE  |   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>2/ 23/82   |  | 2b. HOUR<br>M  |
| 3 SEX<br>M   | 4 RACE<br>Black   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>2 22 29  |   | 6 AGE (IN YEARS LAST BIRTHDAY)<br>53   | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br>N.C.   | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |   | 9 BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.                            |  |
| 10 CITY OR TOWN OF DEATH<br>BALTO  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>407 NORTH BRADFORD ST. |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)                                |  | 12b. KIND OF BUSINESS OR INDUSTRY  |
| 13a. STATE<br>MD   | 13b. COUNTY   | 13c. CITY OR TOWN<br>BALTO   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS<br>407 North Beadford St.  |  |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br>Frank May   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Syble Bennett   |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>Yes  |   | 16b. SOCIAL SECURITY NO.<br>244-34-9614  |   | 17. INFORMANT<br>ADDRESS<br>Frank Mae 102 Juniper Lane, Dundalk                      |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>cardiopulmonary arrest</u><br>1991<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>metastatic cancer</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>1 yr. |   |  |   |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a.   |   |  |   |  |  |
| 19a. DATE OF OPERATION   |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost<br>saw the deceased alive on <u>2/22</u> 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.   |   |  |   |  |  |
| 22b. SIGNATURE<br>Jan Laws Houghton MD   |   | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                  |   | 22c. DATE SIGNED<br>2/23/82  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Jan Laws Houghton   |   | 22e. ADDRESS<br>Cook Raven U.A. Hospital   |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial   |   | 23b. DATE<br>2/26/82   | 23c. NAME OF CEMETERY OR CREMATORY<br>Md. Veteran Cem.  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Crownsville MD   |
| 24 FUNERAL DIRECTOR<br>NAME<br>WM. C. MARCH F/H, INC. 1101 E. North Ave.   |   | 25a. DATE REC'D. BY REGISTRAR<br>FEB 25 1982   |   | 25b. REGISTRAR'S SIGNATURE<br>[Signature]  |  |

NOTICE

WIKI





TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be called.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |   |  | REG. NO.  |  |
|--|--|---|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Laura J. G. MAGGITT   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>2 11 82          |  | 2b. HOUR<br>9 30 AM   |  |
| 3 SEX<br>Female  |  | 4 RACE<br>WHITE   |   | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br>7 1 98  |   | 6 AGE (IN YEARS LAST BIRTHDAY)<br>83<br>YRS.   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Italy   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |   | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.   |
| 10 CITY OR TOWN OF DEATH<br>Baltimore  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Baltimore City Hospitals |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>homemaker  |   | 12b. KIND OF BUSINESS OR INDUSTRY<br>home  |
| 13a. STATE<br>Md.  |  |   | 13b. COUNTY<br>Balto.                                   |  | 13c. STREET ADDRESS<br>3808 E. Pratt St.                        |  |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br>Joseph Graziaplana  |  |   | 15 MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Lucia   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>no   |  |   | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES) |  | 17. INFORMANT<br>ADDRESS<br>Francis Maggitti, 3509 Chesterfield |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Cardio-pulmonary Arrest<br>4100<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) ASCVD.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) prob. MI.<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last |  |   |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>minutes<br>years.  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br>SP @ CVA, SP @ SEMI, angina, CHF.   |  |   |   |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 2/11/82 to 2/11/82, that (I) (we) last saw the deceased alive on 2/11/82, and that it is (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.   |  |   |   |  |   |  |
| 22b. SIGNATURE<br>(Patricia Poorn m)   |  | DEGREE  |   | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>                 |   | 22c. DATE SIGNED<br>2/11/82  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>PATRICIA POORN MD   |  | 22e. ADDRESS<br>Balto City Hosp; Balto, Md.   |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial  |  | 23b. DATE<br>2/15/82  |   | 23c. NAME OF CEMETERY OR CREMATORY<br>St. Stanislaus   |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore, Md.   |
| 24. FUNERAL DIRECTOR<br>NAME<br>Zannino  |  |   |   | 25a. DATE REC'D. BY REGISTRAR<br>FEB 16 1982   |   |  |
| ADDRESS<br>Zannino Funeral Home, 263 S. Conkling St.   |  |   |   | 25b. REGISTRAR'S SIGNATURE<br>Francis Jan Nathan   |   |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified in writing.

MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |   |   | REG. NO. 8 2 0 3 9 8 7  |   |   |   |   |  |  |
|--|--|--|---|---|---|---|---|---|---|--|--|
| 1. FOR STATE REGISTRAR   |  |  |   |   | 2a. DATE OF DEATH MONTH DAY YEAR  |   |   |   | 2b. HOUR  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br>LULU M. MAHAN  |  |  |   |   | 2/2/82  |   |   |   | 2:10 a.m.   |  |  |
| 3. SEX<br>Female   |  | 4. RACE<br>White   |   | 5. DATE OF BIRTH MONTH DAY YEAR<br>04 03 23   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>58 YRS.  |   | IF UNDER 1 YEAR MONTHS DAYS                                   |   | IF UNDER 24 HRS. HOURS MIN.                  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.                        |   |   |   |  |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>ST. AGNES HOSPITAL |   |   |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Accounting Clerk |   | 12b. KIND OF BUSINESS OR INDUSTRY<br>Koppers Co.              |   |  |  |
| 13a. STATE<br>Maryland   |  |  |   |   | 13b. CITY OR TOWN<br>Baltimore  |   | 13c. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 13d. STREET ADDRESS<br>6022 Chesworth Road  |  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>Henry M. Decker   |  |  |   |   | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Helen E. Price  |   |   |   |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>No  |  |  |   |   | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)<br>216-14-0895   |   | 17. INFORMANT ADDRESS<br>Edward F. Mahan Same as # 13   |   |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) 4100 ACUTE MYOCARDIAL INFARCT<br>DUE TO, OR AS A CONSEQUENCE OF (b) CORONARY ARTERIOSCLEROSIS<br>DUE TO, OR AS A CONSEQUENCE OF (c)<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |  |   |   |   |   |   |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)  |  |  |   |   |   |   |   |   |   |  |  |
| 19a. DATE OF OPERATION   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                    |   |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |   |   |   |   |  |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |   |   |   |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from JAN 31, 19 81, to FEB. 2, 19 82, that (I) (we) lost saw the deceased alive on FEB. 2, 19 82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |  |   |   |   |   |   |   |   |  |  |
| 22b. SIGNATURE<br>BERT F. MORTON   |  |  |   |   | DEGREE<br>M.D. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |   |   | 22c. DATE SIGNED  |   |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>BERT F. MORTON  |  |  |   |   | 22e. ADDRESS<br>St. Agnes Hospital, Baltimore, Md.  |   |   |   |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial  |  |  | 23b. DATE<br>2/5/82   |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Crestlawn Cemetery  |   |   | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>Marriottsville Md. |   |  |  |
| 24. FUNERAL DIRECTOR NAME<br>Witzke P.A.   |  |  |   |   | 25a. DATE REC'D. BY REGISTRAR<br>FEB 3 1982   |   |   | 25b. REGISTRAR'S SIGNATURE<br>[Signature]                     |   |  |  |
| 26. ADDRESS<br>1630 Edmondson Avenue, Catonsville, Md. 21228   |  |  |   |   |   |   |   |   |   |  |  |

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

|   |                         |  |   |   |   |  |   |   |
|---|-------------------------|--|---|---|---|--|---|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Sophie E. Mallonee</b>  |                         |  | 2a. DATE KNOWN OF DEATH<br>ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR<br><b>2 3 19 82</b> |   |   | 2b. HOUR<br>M<br><b>7:47 A</b>   |   |   |
| 3. SEX<br><b>Female</b>   | 4. RACE<br><b>White</b> | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>June 16, 1913</b>   | 6. AGE (IN YEARS)<br>(LAST BIRTHDAY)<br><b>68 YRS.</b>  | IF UNDER 1 YR.<br>MONTHS DAYS<br><b>XX</b>  | IF UNDER 24 HRS.<br>HOURS MIN.<br><b>XX</b>                                   | 7c. DATE PRONOUNCED DEAD<br>MONTH DAY YEAR<br><b>2 3 19 82</b>                         |   |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>  |                         | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City,</b> MD.                     |   |   |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   |                         | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Union Memorial Hospital</b> |   |   |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Fur Specialist</b> |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Auman and Workmeister</b> |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |                         |  | 13a. STATE<br><b>Md</b>   |   |   | 13b. COUNTY<br><b>-</b>  |   |   |
| 13c. CITY OR TOWN<br><b>Baltimore</b>   |                         |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>             |   |   | 13e. STREET ADDRESS<br><b>847 W. 36th Street 21211</b>                                 |   |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>John William Greeley</b>   |                         |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Elsie M. Frock</b>                                      |   |   |  |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br><b>NO</b>  |                         |  | 16b. SOCIAL SECURITY NO.<br><b>215 01 0608</b>  |   |   | 17. INFORMANT<br>ADDRESS<br><b>Charles E. Mallonee Same</b>                            |   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Arteriosclerotic Cardiovascular Disease</b><br><b>4292</b><br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b) _____<br>(c) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>DUE TO, OR AS A CONSEQUENCE OF  |                         |  |   |   |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                      |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).   |                         |  |   |   |   |  |   |   |
| 19a. DATE OF OPERATION  |                         |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |   |   |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |                         |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |  |   |   |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK   |                         |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                             |  |   |   |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . |                         |  |   |   |   |  |   |   |
| ACTUAL SIGNATURE<br><b>Virginia L. Dolan</b>  |                         |  | TITLE (SPECIFY)<br><b>M.D. Assistant</b>  |   |   | DATE SIGNED<br><b>2-3-82</b>   |   |   |
| EXAMINER'S NAME<br>(TYPE OR PRINT)<br><b>Virginia L. Dolan, M.D.</b>  |                         |  | ADDRESS<br><b>111 Penn Street</b>   |   |   |  |   |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |                         |  | 23b. DATE<br><b>2/6/82</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Druid Ridge Cemetery</b>             |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Pikesville, Balto. Co. Md</b>      |   |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Burgess Funeral Home</b>   |                         |  | ADDRESS<br><b>3631 Falls Road 21211</b>   |   |   | 25a. DATE REC'D. BY REGISTRAR<br><b>FEB 9 1982</b>                                     |   | 25b. REGISTRAR'S SIGNATURE<br><b>Thom. J. [Signature]</b>         |

June 20, 1917

My dear Sir,

Enclosed find

1000 copies of the

report

of the

committee

on the subject of the

*Very truly yours,*

Respectfully,  
John D. Rockefeller

Chairman of the

Board of Trustees

of the

Rockefeller Foundation



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, properly licensed, may be retained for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be retained by the funeral director within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical certificate must be completed and filed with this one.

FOR  
1- STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 3 9 8 9

REG. NO.

|   |  |  |  |  |   |   |   |   |  |
|---|--|--|--|--|---|---|---|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <i>Henry</i> <i>Manke</i>   |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><i>2 21 82</i>  |  |   | 2b. HOUR<br><i>145/P</i>  |   |   |  |
| 3. SEX<br><i>MALE</i>   |  | 4. RACE<br><i>white</i>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><i>6 28 12</i>   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><i>69</i> YRS.                                 |   | 7. IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN |  |
| 8. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><i>Baltimore, Md.</i>   |  | 9. CITIZEN OF WHAT COUNTRY?<br><i>U.S.A.</i>   |  | 10. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 11. BALTIMORE CITY OR COUNTY OF DEATH<br><i>BALTO CITY</i> MD.                    |   |   |  |
| 12. CITY OR TOWN OF DEATH<br><i>Baltimore</i>   |  | 13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><i>BALTO CITY HOSPITALS</i> |  |  |   | 14. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><i>RETIRED</i> |   | 15. KIND OF BUSINESS OR INDUSTRY<br><i>Industr. Elec. Co</i>      |  |
| 16. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>16a. STATE <i>MD</i> 16b. COUNTY <i>BALTO</i> 16c. CITY OR TOWN <i>Eastpoint</i>   |  |  | 17. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 18. STREET ADDRESS<br><i>7850 Gough Street</i>                            |   |   |   |  |
| 19. FATHER'S NAME<br>FIRST MIDDLE LAST<br><i>William</i> <i>Manke</i>   |  |  | 20. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><i>Flora</i> <i>Brandt</i>                    |  |   |   |   |   |  |
| 21. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <i>Yes</i>  |  |  | 22. SOCIAL SECURITY NO.<br><i>W.W. 11 215071460</i>  |  | 23. INFORMANT<br>ADDRESS<br><i>Marie M. Manke 7850 Gough Street 21224</i> |   |   |   |  |
| 24. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Respiratory failure</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <i>1509</i><br>(b) <i>pulm embolus</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <i></i><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>1 hour</i> |  |  |  |  |   |   |   |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i></i>   |  |  |  |  |   |   |   |   |  |
| 25. DATE OF OPERATION<br><i>12/22/82</i>  |  | 26. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><i>Adenocarcinoma of the Esophagus</i>  |  |  | 27. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |   | 28. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |  |
| 29. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 30. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><i>19</i>  |  | 31. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |   |   |   |   |  |
| 32. INJURY OCCURRED<br>WHILE <input type="checkbox"/> HOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 33. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 34. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |   |   |   |  |
| 35. I certify that (I) (this hospital) attended the deceased from <i>19 82</i> to <i>2-21</i> 19 <i>83</i> , that (I) (we) last saw the deceased alive on <i>2-21</i> 19 <i>82</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.   |  |  |  |  |   |   |   |   |  |
| 36. SIGNATURE<br><i>Andre Brugg</i>   |  |  |  | 37. DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>     |   | 38. DATE SIGNED<br><i>2-21-82</i>   |   |   |  |
| 39. PHYSICIAN'S NAME (TYPE OR PRINT)<br><i>Andre BRUGG</i>  |  |  |  | 40. ADDRESS<br><i>Baltimore City Hospital Baltimore Md</i>   |   |   |   |   |  |
| 41. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><i>Burial</i>   |  | 42. DATE<br><i>2-24-82</i>   |  | 43. NAME OF CEMETERY OR CREMATORY<br><i>Oak Lawn Cemetery</i>  |   | 44. LOCATION<br>CITY OR TOWN COUNTY STATE<br><i>Eastwood, Balto Co. Md.</i>       |   |   |  |
| 45. FUNERAL DIRECTOR<br>NAME ADDRESS<br><i>C.S. Zeiler &amp; Son Inc. 6224 Eastern Avenue</i>   |  |  |  | 46. DATE REC'D. BY REGISTRAR<br><i>FEB 23 1982</i>   |   | 47. REGISTRAR'S SIGNATURE<br><i>James J. [Signature]</i>                          |   |   |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed with the health officer after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH            |  |  |  | REG. NO. 3 2 0 3 9 9 0  |  |  |  |
|---|--|--|--|---|--|--|--|
| 1. FOR STATE REGISTRAR  |  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR  |  |  |  |
| 1. DECEASED NAME FIRST MIDDLE LAST<br>JOSEPH V. MARINER   |  |  |  | February 25, 1982   |  |  |  |
| 3. SEX<br>Male  |  | 4. RACE<br>White   |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>Feb. 14, 1892  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>90 YRS.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Pa.  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>   |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.   |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Edgewood Nursing Home   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Executive   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>A&P Co.   |  |
| 13a. STATE<br>Maryland  |  | 13b. COUNTY  |  | 13c. CITY OR TOWN<br>Baltimore  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>Mortimer Mariner   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Catherine Torpy  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>Yes   |  | 16b. SOCIAL SECURITY NO.<br>215 07 4927  |  |
| 17. INFORMANT ADDRESS<br>Mrs. Margaret M. Mariner   |  | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Malnutrition and Dehydration</u><br>2639<br>DUE TO, OR AS A CONSEQUENCE OF (b)<br>DUE TO, OR AS A CONSEQUENCE OF (c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>1 yr.  |  | PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><u>Diabetes M.</u> <u>Bait disturbance Undiagnosed</u> <u>Fx Hip</u> <u>Smile Dent</u> |  | 19a. DATE OF OPERATION   |  |
| 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER) |  |
| 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                      |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  | 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  |
| 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br>Hopewell Baltimore Md.                     |  | 22a. I certify that (I) (this hospital) attended the deceased from <u>6-15</u> , 19 <u>82</u> , to <u>2-25</u> , 19 <u>82</u> , that (I) <del>was</del> lost<br>saw the deceased alive on <u>2-25</u> , 19 <u>82</u> , and that in (my) <del>last</del> opinion death occurred on the date and hour and from the causes stated<br>above, (I) <del>was</del> (did) not view the body after death. |  | 22b. SIGNATURE<br>William P. Benson, Jr. M.D.<br>22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Dr. William P. Benson, Jr., M.D.  |  | 22c. DATE SIGNED<br>2-26-82  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Cremation                                       |  | 23b. DATE<br>2/27/82   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Greenmount  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Balto., Md.  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Henry W. Jenkins & Sons Co.<br>4905 York Road Balto., Md. 21212 |  | 25a. DATE REC'D BY REGISTRAR<br>FEB 26 1982  |  | 25b. REGISTRAR'S SIGNATURE<br>James Jan Nathan  |  | 25c. REGISTRAR'S NAME  |  |

JOSEPH H. V. 1

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR THE FUNERAL DIRECTOR. PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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DHMH - 17  
(VR A15 ME (5))  
15M2/80

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

|  |                         |   |  |   |   |  |  |  |  |
|--|-------------------------|---|--|---|---|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Michael E. Markel</b>  |                         |   | 2a. DATE KNOWN OF DEATH<br>MONTH <b>2</b> DAY <b>3</b> YEAR <b>1982</b>              |   |   | 2b. HOUR<br>M <b>6:33</b> a. <b>M</b>                                    |  |  |  |
| 3. SEX<br><b>Male</b>  | 4. RACE<br><b>White</b> | 5. DATE OF BIRTH<br>MONTH <b>January</b> DAY <b>2</b> YEAR <b>1982</b>  | 6. AGE (IN YEARS)<br>LAST BIRTHDAY<br>MONTHS <b>1</b> DAYS <b>1</b> YEARS <b>1</b>   | IF UNDER 1 YR.<br>MONTHS <b>1</b> DAYS <b>1</b>   | IF UNDER 24 HRS.<br>HOURS <b>1</b> MIN. <b>1</b>                              | 7c. DATE PRONOUNCED DEAD<br>MONTH <b>2</b> DAY <b>3</b> YEAR <b>1982</b> |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Balto. Md.</b>   |                         | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City,</b> MD.       |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |                         | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Sinai Hospital</b> |  |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>None</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |  |
| 13a. STATE<br><b>Md.</b>   |                         |   | 13b. COUNTY<br><b>Balto.</b>   |   | 13c. CITY OR TOWN<br><b>Owings Mills</b>                                      |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 14. FATHER'S NAME<br>FIRST <b>Unknown</b> MIDDLE <b>Unknown</b> LAST <b>Unknown</b>  |                         |   | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>Deborah</b> MIDDLE <b>L.</b> LAST <b>Markel</b> |   |   | 16. ADDRESS<br><b>Deborah L. Markel Owings Mills, Md.</b>                |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br><b>No</b>   |                         |   | 16b. SOCIAL SECURITY NO.<br><b>None</b>  |   | 17. INFORMANT<br><b>Deborah L. Markel Owings Mills, Md.</b>                   |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br><b>7980</b> IMMEDIATE CAUSE (a) <b>Sudden Infant Death Syndrome</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last:<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____   |                         |   |  |   |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH           |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):  |                         |   |  |   |   |  |  |  |  |
| 19a. DATE OF OPERATION   |                         |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                                    |   |   |  | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |                         |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. <b>19</b>                    |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |                         |   | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)                          |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                             |  |  |  |  |
| 22. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |                         |   |  |   |   |  |  |  |  |
| ACTUAL SIGNATURE<br><b>Virginia L. Dolan</b>   |                         |   | TITLE (SPECIFY)<br><b>Assistant</b>  |   |   | DATE SIGNED<br><b>2-3-82</b>   |  |  |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)<br><b>Virginia L. Dolan, M.D.</b>   |                         |   | ADDRESS<br><b>111 Penn Street</b>  |   |   |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |                         |   | 23b. DATE<br><b>Feb. 5, 82</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Druid Ridge</b>                      |  | 23d. LOCATION<br>CITY OR TOWN <b>Pikesville, Md.</b> COUNTY STATE                    |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Eline Funeral Home</b>  |                         |   | ADDRESS<br><b>Reisterstown, Md. 21136</b>  |   |   | 25a. DATE REC'D. BY REGISTRAR<br><b>FEB 8 1982</b>                       |  | 25b. REGISTRAR'S SIGNATURE<br><b>James J. Harrison</b> |  |

54-03-45

TABLE 1

29 2 095



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  |   |  |   |  |  |  |
|---|--|---|--|---|--|---|--|--|--|
| 1. FOR<br>STATE<br>REGISTRAR  |  | 2. DECEASED NAME<br>(TYPE OR PRINT)   |  |   |  | 2a. DATE OF DEATH   |  | 2b. HOUR   |  |
|   |  | FANNIE E. MARSHALL  |  |   |  | 2/2/82  |  | 9:45 P.M.  |  |
| 3. SEX  |  | 4. RACE   |  | 5. DATE OF BIRTH  |  | 6. AGE (IN YEARS LAST BIRTHDAY)                                     |  | 7. IF UNDER 1 YEAR   |  |
| F   |  | W   |  | 3 31 58   |  | 93 YRS  |  | MONTHS DAYS HOURS MIN.   |  |
| 8. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)   |  | 9. CITIZEN OF WHAT COUNTRY?   |  | 10. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 11. BALTIMORE CITY OR COUNTY OF DEATH                               |  |  |  |
| Maryland  |  | USA   |  |   |  | BALTO CITY MD.  |  |  |  |
| 12. CITY OR TOWN OF DEATH   |  | 13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |   |  | 14. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)     |  | 15. KIND OF BUSINESS OR INDUSTRY                                 |  |
| BALTO, MD   |  | HAMMONDS LANE NRSG CTR  |  |   |  | HOUSEMAKER  |  | home   |  |
| 16. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  | 17. CITY OR TOWN  |  | 18. INSIDE CITY LIMITS?   |  | 19. STREET ADDRESS  |  |  |  |
| Md  |  | AA  |  | Jessup  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 2883 Jessup Road   |  |
| 20. FATHER'S NAME<br>(FIRST MIDDLE LAST)  |  |   |  | 21. MOTHER'S MAIDEN NAME<br>(FIRST MIDDLE LAST)   |  |   |  |  |  |
| Louis Charles Schwartz  |  |   |  | Margaret Raver  |  |   |  |  |  |
| 22. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)   |  | 23. SOCIAL SECURITY NO.   |  | 24. INFORMANT ADDRESS   |  |   |  |  |  |
| No  |  | 215-48-2639   |  | Margaret Watkins 2885 Jessup Road, Jessup, Md   |  |   |  |  |  |
| 25. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE Cause (a) <u>cardiac arrest</u><br><u>4292</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>congestive heart failure.</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>atherosclerotic Cardiovascular disease.</u> |  |   |  |   |  |   |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH                  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)  |  |   |  |   |  |   |  |  |  |
| 26. DATE OF OPERATION   |  | 27. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |  | 28. AUTOPSY?  |  | 29. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH? |  |
|   |  |   |  |   |  | YES <input type="checkbox"/> NO <input type="checkbox"/>            |  | YES <input type="checkbox"/> NO <input type="checkbox"/>         |  |
| 30. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 31. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 32. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)  |  |   |  |  |  |
| 33. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 34. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                     |  | 35. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |   |  |  |  |
|   |  |   |  |   |  |   |  |  |  |
| 36. I certify that (I) (this hospital) attended the deceased from <u>4-11-1975</u> to <u>2-2-1982</u> that (I) (we) last saw the deceased alive on <u>2-2-1982</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.             |  |   |  |   |  |   |  |  |  |
| 37. SIGNATURE   |  |   |  | 38. DEGREE  |  |   |  | 39. DATE SIGNED  |  |
| <u>SEENIVASAN</u>   |  |   |  | MD  |  |   |  |  |  |
| 40. PHYSICIAN'S NAME (TYPE OR PRINT)  |  |   |  | 41. ADDRESS   |  |   |  |  |  |
| SEENIVASAN  |  |   |  | 606 Hammonds Lane, BALTO, Md, 21225   |  |   |  |  |  |
| 42. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)   |  | 43. DATE  |  | 44. NAME OF CEMETERY OR CREMATORY   |  | 45. LOCATION<br>CITY OR TOWN COUNTY STATE                           |  |  |  |
| Burial  |  | Feb. 5, 1982  |  | Meadowridge Memorial Park   |  | Dorsey, Maryland  |  |  |  |
| 46. FUNERAL DIRECTOR<br>NAME  |  |   |  | 47. ADDRESS   |  | 48. DATE RECD. BY REGISTRAR   |  | 49. SIGNATURE  |  |
| Donaldson Funeral Home, Laurel, Md  |  |   |  |   |  | FEB 11 1982   |  |  |  |

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR OFFICE. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

FOR  
1- STATE  
REGISTRAR

|  |  |   |  |   |  |   |  |  |  |   |  |
|--|--|---|--|---|--|---|--|--|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  | FIRST<br>JAMES  |  | MIDDLE<br>O.  |  | LAST<br>MARSHALL  |  | 2a. DATE KNOWN OF DEATH<br>ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR<br>2 6 19 82 |  | 2b. HOUR<br>11:21 a   |  |
| 3. SEX<br>male   |  | 4. RACE<br>negro  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>3 26 14   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>67 YRS.  |  | IF UNDER 1 YR.<br>MONTHS DAYS HOURS MIN.   |  | 2c. DATE PRONOUNCED DEAD<br>MONTH DAY YEAR<br>2 6 19 82                             |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Md.   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.                                      |  |  |  |   |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore   |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>25 N. Mount St. |  |   |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Mechanic                            |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Aircraft                                       |  |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |   |  |   |  |   |  |  |  |   |  |
| 13a. STATE<br>Md.  |  | 13b. COUNTY   |  | 13c. CITY OR TOWN<br>25 N Balto.  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br>25 N. Mount St.   |  |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Charlie Marshall   |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Nancy Johnson  |  |   |  |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br>Yes   |  | (IF YES, GIVE WAR OR DATES)<br>WWII   |  | 16b. SOCIAL SECURITY NO.<br>218-10-6448   |  | 17. INFORMANT<br>Mrs. Marshall Silver Spring, Md.   |  |  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1 DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardiovascular disease</u><br>4292<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____  |  |   |  |   |  |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).<br>Gastro-intestinal hemorrhage  |  |   |  |   |  |   |  |  |  |   |  |
| 19a. DATE OF OPERATION   |  |   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  |   |  |  |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  |   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)                   |  |  |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK  |  |   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |   |  |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |   |  |   |  |   |  |  |  |   |  |
| ACTUAL SIGNATURE<br><i>Ann M. Dixon</i>  |  |   |  | TITLE (SPECIFY)<br>M.D. Assistant   |  |   |  | MEDICAL EXAMINER   |  | DATE SIGNED<br>2-7-82   |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)<br>Ann M. Dixon, M.D.   |  |   |  | ADDRESS<br>111 Penn St.   |  |   |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Removal  |  |   |  | 23b. DATE<br>2/8/82   |  | 23c. NAME OF CEMETERY OR CREMATORY  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE   |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Anatomy Board  |  |   |  |   |  | ADDRESS<br>Balto., Md.  |  | 25a. DATE REC'D. BY REGISTRAR<br>FEB 23 1982   |  | 25b. REGISTRAR'S SIGNATURE<br><i>James J. [Signature]</i>                           |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page-4 may be retained by the hospital or attending physician.

DHMH - 16 50M 1/81  
(VRA 15, 4)

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the informant, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |   |   | REG. NO. 8 2 0 3 9 9 4   |   |   |  |
|--|--|--|---|---|--|---|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Gus August Marsiglia</b>  |  |  |   |   | 2a. DATE OF DEATH MONTH DAY YEAR <b>February 26, 1982</b>                                    |   |   |  |
| 3. SEX <b>Male</b>   |  | 4. RACE <b>White</b>   |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR <b>May 23, 1916</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY) <b>65</b> YRS.                        |   | 7b. HOUR <b>M</b>                            |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>  |  | 7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>   |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.        |   |  |
| 10. CITY OR TOWN OF DEATH <b>Baltimore</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Good Samaritan Hospital</b>                         |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Retired Engineer</b>     |   | 12b. KIND OF BUSINESS OR<br>OCCUPATION <b>City Helper</b>   |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE <b>Maryland</b> 13b. COUNTY <b>Baltimore</b> 13c. CITY OR TOWN <b>Baltimore</b>   |  |  |   |   | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   | 13e. STREET ADDRESS <b>6023 Old Harford Rd</b>  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST <b>Joseph Marsiglia</b>   |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST <b>Margaret Serio</b> |   |  |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN) <b>No</b>  |  | 16b. SOCIAL SECURITY NO. <b>217-12-9449</b>  |   | 17. INFORMANT ADDRESS <b>Mrs Stella R Marsiglia</b>   |  |   | 17. ADDRESS <b>Same</b>   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Prob. Cerebrovascular Accident</b><br><b>4360</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Hypertension</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. |  |  |   |   |  |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).  |  |  |   |   |  |   |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   |   | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>                       |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. <b>19</b>  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>May 26, 1981</b> to <b>Feb. 12, 1982</b> , that (I) (we) last saw the deceased alive on <b>Feb. 12, 1982</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |  |   |   |  |   |   |  |
| 22b. SIGNATURE<br><b>Esperanza Corvera M.D.</b>  |  | DEGREE <b>M.D.</b><br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   |   | 22c. DATE SIGNED<br><b>3/1/82</b>  |   |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Esperanza Corvera M.D.</b>   |  |  |   | 22e. ADDRESS<br><b>5807 Harford Rd Baltimore, Maryland</b>  |  |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>  |  | 23b. DATE <b>3/2/82</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE <b>Baltimore, Maryland</b> |   |  |
| 24. FUNERAL DIRECTOR<br>NAME <b>Leonard J Ruck (Inc)</b><br>ADDRESS <b>Baltimore, Maryland</b>   |  |  |   | 25a. DATE REC'D. BY REGISTRAR 25b. REGISTERED<br><b>MAR 1 1982</b> <b>Frances Jan Nathan</b>  |  |   |   |  |



ALL INFORMATION CONTAINED  
HEREIN IS UNCLASSIFIED  
DATE 11-14-01 BY 60322 UCBAW



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  | 8 2 0 3 9 9 5   |  |   |  |
|--|--|---|--|---|--|---|--|
| FOR<br>STATE<br>REGISTRAR  |  |   |  | REG. NO.  |  |   |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>DELTA V. MARTIS   |  |   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>02-04-82   |  | 2b. HOUR<br>7:21 P.M.   |  |
| 3. SEX<br>Female   |  | 4. RACE<br>White  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>11 04 98  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>83 YRS.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Virginia  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.  |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>SINAI  |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Dietician   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Hospital   |  |
| 13a. STATE<br>Md.  |  | 13b. COUNTY<br>—  |  | 13c. CITY OR TOWN<br>Balto.   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                             |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>James W. Siler   |  | 15. MOTHER'S MAIDEN NAME<br>Cynthia Boitnott  |  | 13e. STREET ADDRESS<br>635 Walporet Ave   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>no   |  | 16b. SOCIAL SECURITY NO.<br>220 07 5799   |  | 17. INFORMANT<br>Ralph H. Minnix 2005 Fitzwarren Road 21209   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) CHRONIC OBSTRUCTIVE PULMONARY DISEASE<br>4960<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last |  |   |  |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |   |  |   |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN IDENTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 1/28/1982, to 2/4/1982, that (I) (we) lost<br>saw the deceased alive on 2/4/1982, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.   |  |   |  |   |  |   |  |
| 22b. SIGNATURE<br>Nelson Beniers   |  | DEGREE<br>M.D. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  |   |  | 22c. DATE SIGNED<br>2/4/82  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>NELSON BENIERS  |  | 22e. ADDRESS<br>SINAI HOSPITAL  |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial   |  | 23b. DATE<br>2/8/82   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Dulaney Valley Mem.   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Cockeysville Balto. Md.   |  |
| 24. FUNERAL DIRECTOR<br>Burgee Funeral Home 3631 Falls Road 21211  |  | 25a. DATE REC'D. BY REGISTRAR<br>FEB 9 1982   |  | 25b. REGISTRAR'S SIGNATURE<br>Ralph H. Minnix   |  |   |  |

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James H. Miller  
Director  
Bureau of  
Prisons  
State of  
California  
San Francisco  
California

220 07 1999 Ralph H. Annix 2005 Attorney and 21200

CLARK UNIVERSITY, NEWARK, NEW JERSEY



James H. Miller  
Director  
Bureau of  
Prisons  
State of  
California  
San Francisco  
California

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of the event.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |   |  |  |  |  |   |  |
|--|--|--|--|---|--|--|--|--|---|--|
| 1. FOR<br>STATE<br>REGISTRAR   |  |  |  |   | REG. NO.   |  |  |  |   |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>GUY G MARSH</b>  |  |  |  |   | 2a. DATE OF DEATH<br>MONTH <b>2</b> DAY <b>28</b> YEAR <b>82</b><br>7b. HOUR <b>12</b> M |  |  |  |   |  |
| 3. SEX<br><b>Male</b>  |  | 4. RACE<br><b>White</b>  |  | 5. DATE OF BIRTH<br>MONTH <b>1</b> DAY <b>17</b> YEAR <b>11</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>71</b> YRS.  |  | 7b. IF UNDER 1 YEAR<br>MONTHS <b>0</b> DAYS <b>0</b> HOURS <b>0</b> MIN. |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Md.</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.  |  |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Balto.</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>St. Agnes Hospital</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Meat Packer</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY  |   |  |
| 13a. STATE<br><b>Md.</b>   |  |  |  |   | 13b. COUNTY<br><b>Balto.</b>   |  | 13c. CITY OR TOWN<br><b>Balto.</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 14. FATHER'S NAME<br>FIRST <b>Harry</b> MIDDLE <b>T.</b> LAST <b>Marsh</b>   |  |  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>Bessie</b> MIDDLE <b>H.</b> LAST <b>Orem</b>        |  |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>Yes</b>   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>1944-46</b>  |  | 17. INFORMANT <b>2222 Christian Street,</b><br><b>Mrs. Roselyn E. Marsh</b> <b>21223</b>  |  |  |  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARDIAC ARRHYTHMIA; HYPOXEMIA</b><br><b>5715</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>GI HEMORRHAGE; ESOPHAGEAL VARICES</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>NUTRITIONAL CIRRHOSIS</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |  |  |   |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).<br><b>DIABETES MELLITUS</b>  |  |  |  |   |  |  |  |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>     |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. <b>19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |  |  |   |  |  |  |  |   |  |
| 22b. SIGNATURE<br><i>Michael E. Pelayo</i>   |  |  |  | DEGREE<br><b>MD</b>   |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br><b>2/28/82</b>                                       |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  |  |  | 22e. ADDRESS  |  |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>3-3-82</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Loudon Park Cem.</b>   |  | 23d. LOCATION<br>CITY OR TOWN <b>Balto.</b> COUNTY <b>Md.</b> STATE <b>Md.</b>   |  |  |   |  |
| 24. FUNERAL DIRECTOR<br><b>P. A. Truman Schweg</b> <b>3512 Frederick Ave</b> <b>BALTO.</b> <b>21208</b> <b>CHINA</b> <b>15</b> <b>MAR 4 1982</b> <b>Truman Schweg</b>  |  |  |  |   |  |  |  |  |   |  |

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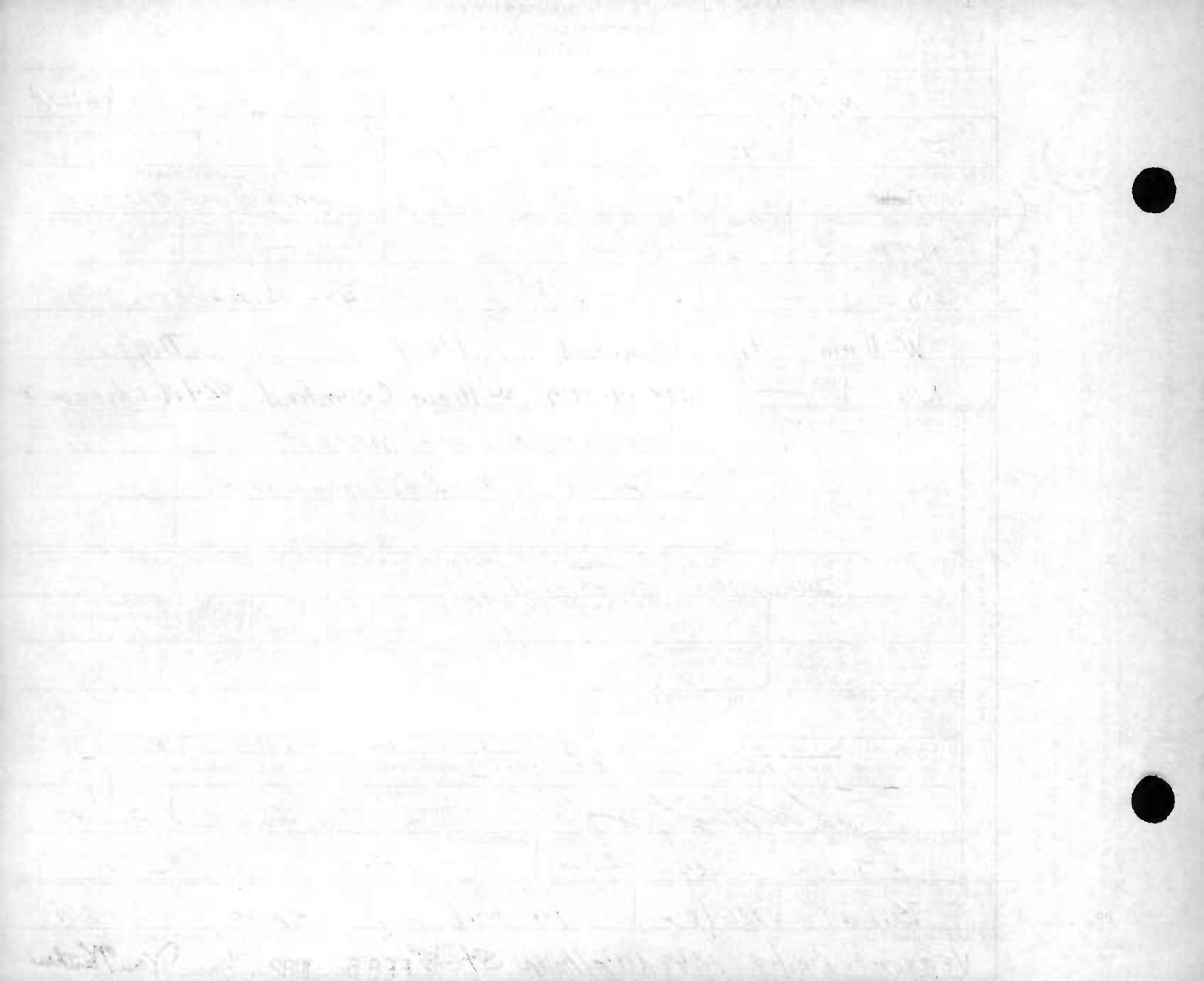
CHARTERED ACCOUNTANTS

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 2 and 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| 1. FOR STATE REGISTRAR   |  | STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |   | REG. NO.   |  |
|--|--|--|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  | FIRST  | MIDDLE  | LAST   | 2a. DATE OF DEATH MONTH DAY YEAR             |
| MARY E. MASON  |  |  |   |  | 2b. HOUR 6:42 PM                             |
| 3. SEX   | 4. RACE  | 5. DATE OF BIRTH   |   | 6. AGE (IN YEARS LAST BIRTHDAY)  | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.       |
| F  | B  | 12 21 14   |   | 67 YRS.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  | 7b. CITIZEN OF WHAT COUNTRY?   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH   |  |
| Maryland   | USA  |  |   | BALTIMORE CITY MD.   |  |
| 10. CITY OR TOWN OF DEATH  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) |  | 12b. KIND OF BUSINESS OR INDUSTRY            |
| BALTIMORE  | LUTHERAN   |  |   |  |  |
| 13a. STATE   |  | 13b. COUNTY  | 13c. CITY OR TOWN   | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS                          |
| MD   |  |  | BALTIMORE   |  | 424 N. EDGEWOOD ST                           |
| 14. FATHER'S NAME  |  | 15. MOTHER'S MAIDEN NAME   |   |  |  |
| FIRST MIDDLE LAST  |  | FIRST MIDDLE LAST  |   |  |  |
| William H. Cramford  |  | MARY Diggs   |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)  |  | 16b. SOCIAL SECURITY NO.   |   | 17. INFORMANT ADDRESS  |  |
| NO   |  | 218-14-3899  |   | William Cramford 424 N. Edgewood St  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>CARDIO PULMONARY ARREST</u><br>5728<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>HEPATIC &amp; RENAL FAILURE</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____   |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)<br><u>DIABETES MELLITUS</u>   |  |  |   |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>  |  |  |   |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)               |  |
|  |  | P.M. 19  |   |  |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |
|  |  |  |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>JAN 19</u> , 19 <u>82</u> , to <u>FEB 2</u> , 19 <u>82</u> , that (I) (we) lost saw the deceased alive on <u>FEB 2</u> , 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |   |  |  |
| 22b. SIGNATURE   |  | DEGREE   |   | 22c. DATE SIGNED   |  |
|  |  |  |   | 22-82  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  | 22e. ADDRESS   |   |  |  |
| JOHN H. WEIGER MD  |  | LUTHERAN HOSPITAL  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  | 23b. DATE  | 23c. NAME OF CEMETERY OR CREMATORY                            | 23d. LOCATION CITY OR TOWN COUNTY STATE  |  |
| Burial   |  | 2/6/82   | MT. Auburn  | BALTO MD   |  |
| 24. FUNERAL DIRECTOR NAME  |  | 25a. DATE REC'D. BY REGISTRAR  |   | 25b. REGISTRAR'S SIGNATURE   |  |
| VERNON R. Bailey 1348 N. CALHOUN ST  |  | FEB 5 1982   |   | James Van Natten   |  |





STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE

## CERTIFICATE OF DEATH

REG. NO.

FOR  
1 - STATE  
REGISTRAR

|  |  |  |  |   |  |   |  |
|--|--|--|--|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Thora B Mason</b>  |  |  | 2a. DATE OF DEATH<br>MONTH <b>2</b> DAY <b>15</b> YEAR <b>82</b> |   |  | 2b. HOUR<br><b>6:05</b> M   |  |
| 3 SEX<br><b>Female</b>   |  | 4 RACE<br><b>White</b>   |  | 5. DATE OF BIRTH<br><b>January 9, 1897</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>85</b>  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Penna.</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWER <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |  | 11. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br><b>Jenkins Memorial Home<br/>1000 S. Caton Ave. Balt; Md. 21229</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Housewife</b>  |  |
| 13a. STATE<br><b>Maryland</b>  |  | 13b. COUNTY  |  | 13c. CITY OR TOWN<br><b>Baltimore</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                               |  |
| 14. FATHER'S NAME<br>FIRST <b>Axel</b> MIDDLE <b>P.C.</b> LAST <b>Bistrup</b>  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>Maude</b> MIDDLE <b>E</b> LAST <b>Whitehead</b>   |  |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>217-03-2002</b>   |  | 17. INFORMANT<br>ADDRESS<br><b>Mrs Virginia M Ball Same</b>   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY:<br><b>1990</b><br>IMMEDIATE CAUSE (a) <b>Spontaneous - R.O.</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>C.D.L.D. - due to Emphysema</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>Heart Attack - Atrial Fibr</b><br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) |  |  |  |   |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>2-16-74</b> , 19____, to <b>2-15-82</b> , 19____, that (I) (we) last saw the deceased alive on <b>2-9-82</b> , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |  |  |   |  |   |  |
| 22b. SIGNATURE<br><b>George Higon</b>  |  | DEGREE   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                  |  | 22c. DATE SIGNED<br><b>2-15-82</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>GEORGE HIGON</b>   |  | 22e. ADDRESS<br><b>3350 - Wilkins Pk Baltimore, Md</b>   |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>XXXXX Cremation</b>   |  | 23b. DATE<br><b>2/16/82</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Greenmount</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore, Maryland</b>  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Leonard J Ruck Inc. Baltimore, Maryland</b>   |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>FEB 16 1982</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>James J. Natch</b>   |  |

MEDICAL CERTIFICATION

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at the time of death.



1900

1900

Leaning Memorial Home  
1000 S. Cotton Ave. Baltimore, Md. 21225

1900

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  |   |  | 8 2 0 3 9 9 9  |  |
|---|--|---|--|---|--|--|--|
| 1. FOR STATE REGISTRAR  |  | REG. NO.  |  |   |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>LOUISE R. MASSOK</b>   |  |   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>2-22-82</b>   |  | 2b. HOUR<br><b>11:05PM</b>   |  |
| 3. SEX<br><b>Female</b>   |  | 4. RACE<br><b>White</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>January 1, 1903</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>79</b> YRS.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Poland</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City, Maryland MD.</b>  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Church Hospital, Inc.</b> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Labor</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Esskay Meat Co.</b>  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |  |  |
| 13a. STATE<br><b>Maryland</b>   |  | 13b. COUNTY<br><b>-----</b>   |  | 13c. CITY OR TOWN<br><b>Baltimore</b>   |  | 13e. STREET ADDRESS<br><b>111 S. Ann Street</b>  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>George A. Massok</b>   |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Ann Cfajna</b>  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>158-09-1038</b>   |  | 17. INFORMANT ADDRESS<br><b>Joseph A. Massok West Point, Virginia</b>   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>ACUTE MYOCARDIAL INFARCTION</b><br><b>4100</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>CORONARY ARTERY INSUFFICIENCY<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>DUE TO, OR AS A CONSEQUENCE OF<br>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE<br>(c) |  |   |  |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):<br><b>POORLY CONTROLLED DIABETES MELLITUS, DIGTOXICITY</b>   |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a. I certify that (1) this hospital attended the deceased from <b>2-21</b> , 19 <b>82</b> , to <b>2-22</b> , 19 <b>82</b> , that (1) (well) last saw the deceased alive on <b>2-22</b> , 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I/we) (did) (did not) view the body after death.  |  |   |  |   |  |  |  |
| 22b. SIGNATURE<br><b>AF Nours MD</b>  |  |   |  | DEGREE<br><b>AF Nours</b>   |  | 22c. DATE SIGNED<br><b>2/23/82</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>AF Nours</b>  |  |   |  | 22e. ADDRESS<br><b>CHURCH HOSPITAL CORPORATION 100 N. BROADWAY BALTIMORE, MARYLAND 21231</b>  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>Feb 25, 82</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>St. Theresa Cem</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>West Point, Virginia</b>  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Dippel Funeral Homes, Inc.</b>   |  |   |  | ADDRESS<br><b>7110 Belair Road</b>  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>FEB 25 1982</b>  |  |
|   |  |   |  | 25b. REGISTRAR'S SIGNATURE<br><b>James J. [Signature]</b>   |  |  |  |

1022177

AT HOME  
SUN 11

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 4 0 0 0

REG. NO.

|  |   |   |  |  |  |  |  |
|--|---|---|--|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <u>JENNIE S MATHEWSON</u>  |   |   | 2a. DATE OF DEATH MONTH DAY YEAR <u>2.5.82</u> |  |  | 2b. HOUR <u>12:50 PM</u>   |  |
| 3. SEX<br><u>FEMALE</u>  | 4. RACE<br><u>WHITE</u>   | 5. DATE OF BIRTH<br>MONTH DAY YEAR <u>7 9 78</u>  |  | 6. AGE (IN YEARS-LAST BIRTHDAY)<br><u>103</u> YRS.   |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><u>Scotland</u>   | 7b. CITIZEN OF WHAT COUNTRY?<br><u>USA</u>  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><u>Baltimore</u> MD.   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><u>Baltimore</u>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><u>University Hospital</u> |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><u>Housewife</u>   |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE <u>Maryland</u> 13b. COUNTY <u>Baltimore</u> 13c. CITY OR TOWN <u>Linthicum</u>  |   |   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 13e. STREET ADDRESS<br><u>30102 Kdale Rd.</u>  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><u>Robert</u> <u>-----</u> <u>Dey</u>  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><u>Charlotte</u> <u>-----</u> <u>Cameron</u>   |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><u>No</u>  |   | 16b. SOCIAL SECURITY NO.<br><u>Unknown</u>  |  | 17. INFORMANT ADDRESS<br><u>Mrs. Jean Ortgies, Same as above</u>   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardiopulmonary arrest</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>aspiration pneumonia</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>5070</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |   |   |  |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <u>-----</u>  |   |   |  |  |  |  |  |
| 19a. DATE OF OPERATION   |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><u>P.M.</u> <u>19</u>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART I OR PART 2)   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>1-31-1982</u> to <u>2-5-1982</u> , that (I) (we) lost saw the deceased alive on <u>2-5-1982</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |   |   |  |  |  |  |  |
| 22b. SIGNATURE<br><u>Louis Solomon MD</u>  |   |   |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br><u>2/5/82</u>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>LOUIS SOLOMON</u>  |   |   |  | 22e. ADDRESS<br><u>225.6 GREEN ST, UNIVERSITY HOSPITAL</u>   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><u>Burial</u>   |   | 23b. DATE<br><u>Feb. 9, 1982</u>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Kensico Cemetery</u>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><u>Valhalla, Westchester Co. N.Y.</u>  |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><u>McCully Funeral Home, 237 E. Patapsco Ave. Balto.</u>   |   |   |  | 25a. DATE REC'D BY REGISTRAR<br><u>FEB 10 1982</u>   |  |  |  |

1. 1/2 cup of water  
2. 1/2 cup of oil  
3. 1/2 cup of vinegar  
4. 1/2 cup of lemon juice  
5. 1/2 cup of salt  
6. 1/2 cup of sugar  
7. 1/2 cup of butter  
8. 1/2 cup of margarine  
9. 1/2 cup of shortening  
10. 1/2 cup of lard

11. 1/2 cup of cornstarch  
12. 1/2 cup of flour  
13. 1/2 cup of baking powder  
14. 1/2 cup of baking soda  
15. 1/2 cup of yeast  
16. 1/2 cup of instant yeast  
17. 1/2 cup of active dry yeast  
18. 1/2 cup of dry yeast  
19. 1/2 cup of compressed yeast  
20. 1/2 cup of fresh yeast

21. 1/2 cup of dry milk powder  
22. 1/2 cup of instant milk powder  
23. 1/2 cup of active dry milk powder  
24. 1/2 cup of fresh milk powder  
25. 1/2 cup of dry milk solids  
26. 1/2 cup of instant milk solids  
27. 1/2 cup of active dry milk solids  
28. 1/2 cup of fresh milk solids  
29. 1/2 cup of dry milk whey  
30. 1/2 cup of instant milk whey

31. 1/2 cup of dry milk curd  
32. 1/2 cup of instant milk curd  
33. 1/2 cup of active dry milk curd  
34. 1/2 cup of fresh milk curd  
35. 1/2 cup of dry milk casein  
36. 1/2 cup of instant milk casein

37. 1/2 cup of active dry milk casein  
38. 1/2 cup of fresh milk casein  
39. 1/2 cup of dry milk whey solids  
40. 1/2 cup of instant milk whey solids

41. 1/2 cup of active dry milk whey solids  
42. 1/2 cup of fresh milk whey solids  
43. 1/2 cup of dry milk curd solids  
44. 1/2 cup of instant milk curd solids

45. 1/2 cup of active dry milk curd solids  
46. 1/2 cup of fresh milk curd solids  
47. 1/2 cup of dry milk casein solids  
48. 1/2 cup of instant milk casein solids

49. 1/2 cup of active dry milk casein solids  
50. 1/2 cup of fresh milk casein solids  
51. 1/2 cup of dry milk whey solids  
52. 1/2 cup of instant milk whey solids

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Item 15 per phone 2/10/82 daa

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO. 8 2 0 4 0 0 1

1- FOR STATE REGISTRAR

1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Catherine *DELL* MATTHEWS

2a DATE OF DEATH MONTH DAY YEAR February 5, 1982

2b HOUR 11:30<sup>a</sup> M

3 SEX *Female* 4 RACE *Negro* 5 DATE OF BIRTH MONTH DAY YEAR 7 31 18

6 AGE (IN YEARS LAST BIRTHDAY) 71 YRS. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.

7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) *Baltimore MD* 7b CITIZEN OF WHAT COUNTRY? *USA* 8 MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

9 BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.

10 CITY OR TOWN OF DEATH Baltimore 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Maryland General Hospital

12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) *None* 12b. KIND OF BUSINESS OR INDUSTRY *None*

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE *MD* 13b. COUNTY *Baltimore* 13c. CITY OR TOWN *Baltimore* 13d. INSIDE CITY LIMITS? YES ☒ NO ☐

13e STREET ADDRESS *1100 Bolton Street*

14 FATHER'S NAME FIRST MIDDLE LAST *Arthur Bell* 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST *Burtha McLaughlin*

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) 16b. SOCIAL SECURITY NO. 17 INFORMANT ADDRESS *Marian F. Sherman 212 N. Calver St.*

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))  
PART I. DEATH WAS CAUSED BY:  
IMMEDIATE CAUSE (a) *Cardiopulmonary arrest*  
*4280* DUE TO, OR AS A CONSEQUENCE OF (b) *Congestive heart failure*  
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c)  
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  
*10 minutes*  
*3 days*

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I:  
*Cerebral vascular accident; Decubiti; severe malnutrition.*

19a DATE OF OPERATION January 20, 1981 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Sacral Decubiti 20a. AUTOPSY? YES ☐ NO ☒ 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) 21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that ~~XX~~ (this hospital) attended the deceased from *December 26* 19 *81*, to *February 5* 19 *82*, that ~~XX~~ (we) lost saw the deceased alive on *February 5* 19 *82*, and that in ~~my~~ (our) opinion death occurred on the date and hour and from the causes stated above. ~~(X we)~~ (did) (XXXX) view the body after death.

22b. SIGNATURE *Robert Ammlung* DEGREE *MD* ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☒ 22c. DATE SIGNED 2/5/82

22d. PHYSICIAN'S NAME (TYPE OR PRINT) Robert Ammlung, M.D. 22e. ADDRESS c/o Maryland General Hospital

23a. BURIAL, CREMATION, REMOVAL (SEE INSTRUCTIONS) *Burial* 23b. DATE *2/10/82* 23c. NAME OF CEMETERY OR CREMATORY *St. Agnes* 23d. LOCATION *Baltimore* COUNTY *MD* STATE

24. FUNERAL DIRECTOR *James J. Lyons (364) 9111* 25a. DATE REC'D. BY REGISTRAR FEB 8 1982 25b. REGISTRAR'S SIGNATURE *Francis J. Matthews*

UNITED STATES MARINE CORPS



1. Name: [illegible]  
 2. Service Number: [illegible]  
 3. Grade: [illegible]  
 4. Branch: [illegible]  
 5. Station: [illegible]  
 6. Date: [illegible]  
 7. Signature: [illegible]  
 8. Remarks: [illegible]  
 9. [illegible]  
 10. [illegible]  
 11. [illegible]  
 12. [illegible]  
 13. [illegible]  
 14. [illegible]  
 15. [illegible]  
 16. [illegible]  
 17. [illegible]  
 18. [illegible]  
 19. [illegible]  
 20. [illegible]

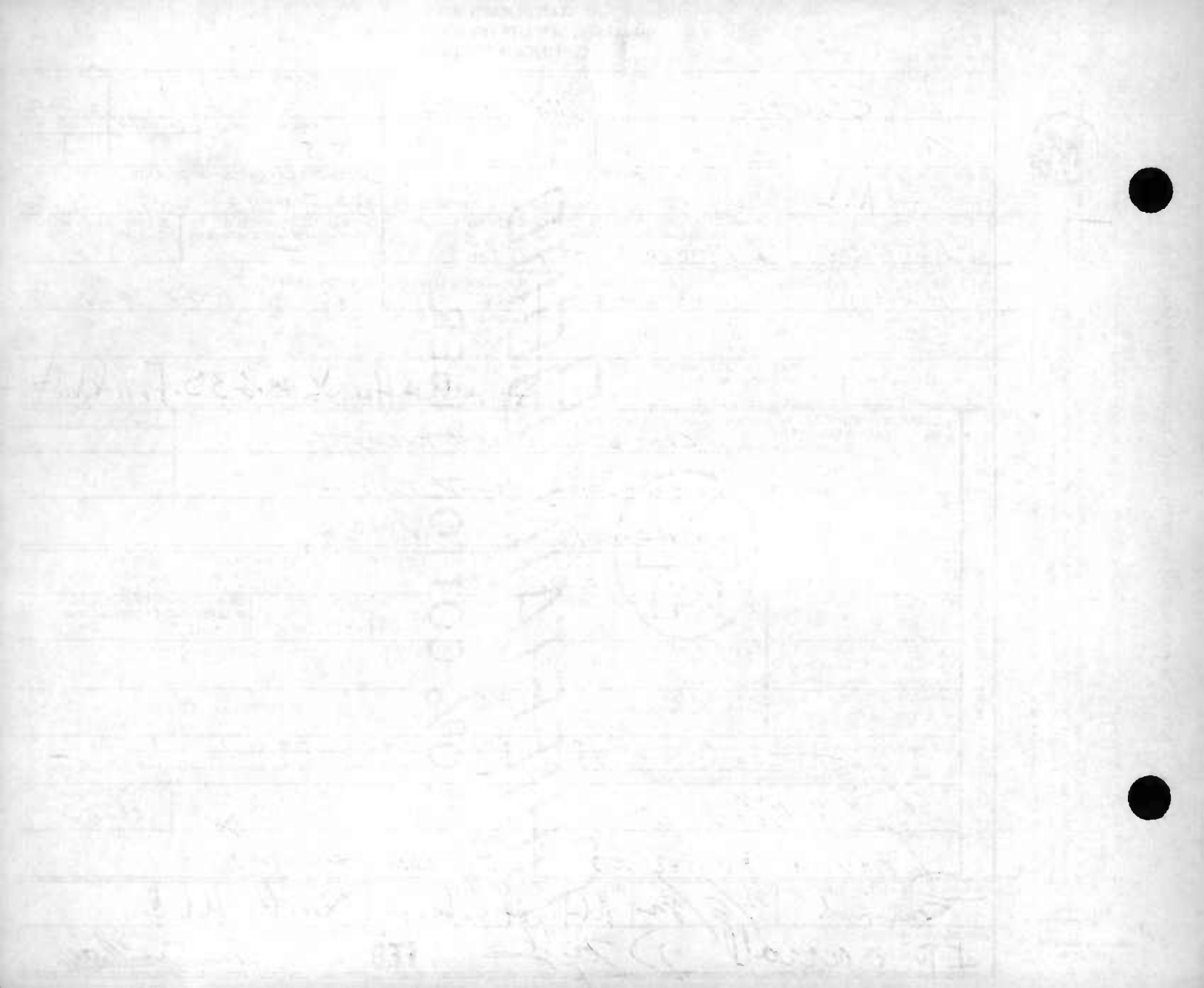


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 27 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |   |  | 8 2 0 4 0 0 2  |   |
|---|--|---|--|--|---|
| 1. FOR STATE REGISTRAR  |  |   |  | CERTIFICATE OF DEATH   |   |
| REG. NO.  |  |   |  |  |   |
| 1. DECEASED NAME (TYPE OR PRINT)  |  |   | FIRST  | MIDDLE   | LAST  |
| COLLETTE  |  |   |  |  | MATTHEWS  |
| 3. SEX  |  |   | 4. RACE  | 5. DATE OF BIRTH   |   |
| 1   |  |   | B  | 6-2-93   |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  |   | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. AGE (IN YEARS LAST BIRTHDAY)                                     |
| MD  |  |   | U.S.A.   |  | 88  |
| 10. CITY OR TOWN OF DEATH   |  |   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |
| BALTIMORE   |  |   | LUTHERAN HOSPITAL  |  | BALTIMORE CITY MD.  |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)   |  |   | 12b. KIND OF BUSINESS OR INDUSTRY  |  |   |
|   |  |   |  |  |   |
| 13a. STATE  |  |   | 13b. COUNTY  | 13c. CITY OR TOWN  | 13d. INSIDE CITY LIMITS?  |
| MARYLAND  |  |   |  | BALTIMORE  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 14. FATHER'S NAME   |  |   | 15. MOTHER'S MAIDEN NAME   |  | 13e. STREET ADDRESS   |
|   |  |   |  |  | 140 W. LAFAYETTE ST.  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)   |  |   | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT   |
|   |  |   |  |  | Doretha Hawkins   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY:   |  |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                        |
| IMMEDIATE CAUSE (a) 4100 CARDIOPULMONARY ARREST   |  |   |  |  |   |
| DUE TO, OR AS A CONSEQUENCE OF (b) CONGESTIVE HEART FAILURE   |  |   |  |  |   |
| DUE TO, OR AS A CONSEQUENCE OF (c) MYOCARDIAL INFARCTIONS   |  |   |  |  |   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)  |  |   |  |  |   |
| CHRONIC RENAL FAILURE   |  |   |  |  |   |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                    |  | 20a. AUTOPSY?  |   |
|   |  |   |  | YES <input type="checkbox"/> NO <input type="checkbox"/>                       |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR                        |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2) |   |
|   |  | P.M. 19   |  |  |   |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                 |   |
|   |  |   |  |  |   |
| 22a. I certify that (I) (this hospital) attended the deceased from JAN. 29, 19 82, to FEB 1, 19 82, that (I) (we) last saw the deceased alive on FEB 1, 19 82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |  |   |  |  |   |
| 22b. SIGNATURE  |  |   |  | 22c. DATE SIGNED   |   |
| John H. Neiter MD   |  |   |  | 2/1/82   |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  |   |  | 22e. ADDRESS   |   |
| JOHN H. NEITER MD   |  |   |  | LUTHERAN HOSPITAL  |   |
| 23a. BURIAL, CREMATION, REMOVAL   |  | 23b. DATE   |  | 23c. NAME OF CEMETERY OR CREMATORY   |   |
|   |  | 2/6/82  |  | Mt. Auburn   |   |
| 23d. LOCATION   |  | 23e. CITY OR TOWN   |  | 23f. COUNTY  |   |
|   |  | Baltimore   |  | MD.  |   |
| 24. FUNERAL DIRECTOR  |  |   | 25a. DATE REC'D. BY REGISTRAR  |  |   |
| JP. canal   |  |   | FEB 4 1982   |  |   |
| 25b. REGISTRAR'S SIGNATURE  |  |   |  |  |   |
|   |  |   |  |  |   |



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 4 0 0 3

1- FOR  
STATE  
REGISTRAR

REG. NO.

|  |  |   |   |   |  |   |  |  |                                     |  |  |
|--|--|---|---|---|--|---|--|--|-------------------------------------|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Albert Mazeroff</b>   |  |   | 2a. DATE OF DEATH<br>MONTH <b>2</b> DAY <b>8</b> YEAR <b>82</b> |   |  | 2b. HOUR<br><b>9:15</b> P.M.  |  |  |                                     |  |  |
| 3. SEX<br><b>MALE</b>  |  | 4. RACE<br><b>Cau CASIAN</b>  |   | 5. DATE OF BIRTH<br>MONTH <b>6</b> DAY <b>15</b> YEAR <b>11</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>70</b> YRS.   |  | IF UNDER 1 YEAR<br>MONTHS <b>0</b> DAYS <b>0</b>   |                                     | IF UNDER 22 HRS<br>HOURS <b>0</b> MIN. <b>0</b>                              |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Balto. City</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>CITY</b>   |  |  |                                     |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTO</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>SINAI HOSP.</b> |   |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Policeman</b>  |  |  | 12b. CITY OF BIRTH<br><b>BALTO.</b> |  |  |
| 13a. STATE<br><b>MD</b>  |  | 13b. COUNTY<br><b>XX</b>  |   | 13c. CITY OR TOWN<br><b>BALTIMORE</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 13e. STREET ADDRESS<br><b>APT. C 3121 Bancroft Rd 2125</b>   |                                     |  |  |
| 14. FATHER'S NAME<br>FIRST <b>Israel</b> MIDDLE <b>MAZEROFF</b> LAST <b>MAZEROFF</b>   |  |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>Lena</b> MIDDLE <b>ASCH</b> LAST <b>ASCH</b>   |  |   |  |  |                                     |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>213-145461</b>   |   | 17. INFORMANT<br><b>Wife - Mildred MAZEROFF</b>   |  | ADDRESS<br><b>3121 BANCROFT RD. APT. C #2125</b>  |  |  |                                     |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Carcinomatosis</b><br><b>1539</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Ca Colon</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(c) <b>2 yrs</b> |  |   |   |   |  |   |  |  |                                     | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>1 yr.</b><br><b>2 yrs</b> |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |   |   |   |  |   |  |  |                                     |  |  |
| 19a. DATE OF OPERATION<br><b>12/2/81</b>   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>Proctapsed Colostomy</b>   |   |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                                     |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |  |                                     |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET<br><b>2435 W. Belvedere Ave 2125</b>  |  | CITY OR TOWN<br><b>ROSEDALE</b>   |  | COUNTY<br><b>BALTO.</b>  |                                     | STATE<br><b>MD</b>   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>2/81</b> to <b>2/82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |   |   |   |  |   |  |  |                                     |  |  |
| 22b. SIGNATURE<br><b>SCHULTZ, MICHAEL J.</b>   |  |   |   |   |  | DEGREE<br><b>ATTENDING PHYSICIAN</b> <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br><b>2/8/82</b>  |                                     |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>BURIAL</b>   |  |   |   |   |  | 23b. DATE<br><b>FEB. 10, 1982</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>RIGA KURLAND VEREIN</b>   |                                     | 23d. LOCATION<br>CITY OR TOWN<br><b>ROSEDALE</b>                             |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>SOL LEVINSON &amp; BROS., INC.</b>  |  |   |   |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>FEB 17 1982</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>James J. Mather</b>   |                                     |  |  |
| 6010 REISTERSTOWN RD. BALTO., MD 21215   |  |   |   |   |  |   |  |  |                                     |  |  |

1. Name of the plant or animal: *...*  
2. Locality: *...*  
3. Date of collection: *...*  
4. Collector: *...*  
5. Description: *...*  
6. Remarks: *...*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical certificate must be completed and signed.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |   |   |  |   |  |                                   |  | REG. NO.                                     |  |
|--|--|--|---|---|--|---|--|-----------------------------------|--|--|--|
| 1. FOR STATE REGISTRAR   |  |  |   |   | 8 2 0 4 0 0 4  |   |  |                                   |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT)   |  |  |   |   | 2a. DATE OF DEATH  |   |  |                                   |  | 2b. HOUR                                     |  |
| FIRST MIDDLE LAST<br>Wilbert McClamb Sr  |  |  |   |   | MONTH DAY YEAR<br>2 7 1982   |   |  |                                   |  | M  |  |
| 3. SEX   |  | 4. RACE  |   | 5. DATE OF BIRTH  |  | 6. AGE (IN YEARS LAST BIRTHDAY)                                     |  | IF UNDER 1 YEAR                   |  | IF UNDER 24 HRS.                             |  |
| male   |  | black  |   | MONTH DAY YEAR<br>9 10 03   |  | 78 YRS  |  | MONTHS DAYS                       |  | HOURS MIN.                                   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY?   |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |  |                                   |  |  |  |
| S. C.  |  | USA  |   |   |  | Baltimore city MD.  |  |                                   |  |  |  |
| 11. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |   |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)       |  | 12b. KIND OF BUSINESS OR INDUSTRY |  |  |  |
| Baltimore  |  | 6225 York Road   |   |   |  |   |  |                                   |  |  |  |
| 13a. STATE   |  | 13b. COUNTY  |   | 13c. CITY OR TOWN   |  | 13d. INSIDE CITY LIMITS?  |  | 13e. STREET ADDRESS               |  |  |  |
| Md   |  |  |   | Baltimore   |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 6225 York Road                    |  |  |  |
| 14. FATHER'S NAME  |  |  |   |   | 15. MOTHER'S MAIDEN NAME   |   |  |                                   |  |  |  |
| FIRST MIDDLE LAST<br>Unknown   |  |  |   |   | FIRST MIDDLE LAST<br>Unknown   |   |  |                                   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)  |  |  |   |   | 16b. SOCIAL SECURITY NO.   |   | 17. INFORMANT ADDRESS                                    |                                   |  |  |  |
| No   |  |  |   |   | N/A  |   | Shirley M. Brandon 1500 Stonewood Road                   |                                   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |  |  |   |   |  |   |  |                                   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) ① Pulmonary edema  |  |  |   |   |  |   |  |                                   |  |  |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost  |  |  |   |   |  |   |  |                                   |  | 70   |  |
| DUE TO, OR AS A CONSEQUENCE OF (b) ② Asphyxia  |  |  |   |   |  |   |  |                                   |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF (c) ③ Metastatic cancer prostate  |  |  |   |   |  |   |  |                                   |  | 3-403  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 10  |  |  |   |   |  |   |  |                                   |  |  |  |
| 19a. DATE OF OPERATION   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                  |   |  |   | 20a. AUTOPSY?  |                                   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |  |  |
|  |  |  |   |   |  |   | YES <input type="checkbox"/> NO <input type="checkbox"/> |                                   | YES <input type="checkbox"/> NO <input type="checkbox"/>       |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  | 21b. TIME OF INJURY   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)  |   |  |                                   |  |  |  |
|  |  |  | HOUR A.M. MONTH DAY YEAR<br>P.M. 19                               |   |  |   |  |                                   |  |  |  |
| 21d. INJURY OCCURRED   |  |  | 21e. PLACE OF INJURY (AT HOME STREET FACTORY, OFFICE, FARM, ETC.) |   | 21f. LOCATION  |   |  |                                   |  |  |  |
| WHILE <input type="checkbox"/> AT WORK NO <input type="checkbox"/> WHILE <input type="checkbox"/> AT WORK  |  |  |   |   | CITY OR TOWN COUNTY STATE  |   |  |                                   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 1978, 19, to Feb 4, 19 82, that (I) (we) lost saw the deceased alive on 2/3/82, 19 82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |   |   |  |   |  |                                   |  |  |  |
| 22b. SIGNATURE   |  |  |   |   | DEGREE   |   |  |                                   |  | 22c. DATE SIGNED                             |  |
| Joel H. Cherry, MD   |  |  |   |   | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   |  |                                   |  | 3/10/82                                      |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  |  |   |   | 22e. ADDRESS   |   |  |                                   |  |  |  |
| Joel H. Cherry   |  |  |   |   | 2000 Cold Springs Lane 21410   |   |  |                                   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  |  | 23b. DATE   |   | 23c. NAME OF CEMETERY OR CREMATORY   |   |  | 23d. LOCATION                     |  |  |  |
| Burial   |  |  | 2/12/82   |   | Baltimore Cemetery   |   |  | Baltimore COUNTY STATE<br>Md      |  |  |  |
| 24. FUNERAL DIRECTOR   |  |  |   |   | 25a. DATE REC'D. BY REGISTRAR  |   |  | 25b. REGISTRAR'S SIGNATURE        |  |  |  |
| NAME ADDRESS<br>William C. March F/H 1101 E. North Avenue  |  |  |   |   | FEB 11 1982  |   |  | Name Jan Mathen                   |  |  |  |



FEB 11 1967



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrars, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  |   |  |   |  |  |  | 8 2 0 4 0 0 5                                |  |
|--|--|---|--|---|--|---|--|--|--|--|--|
| FOR<br>STATE<br>REGISTRAR  |  | REG. NO.  |  |   |  |   |  |  |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  | FIRST<br><i>Joseph</i>  |  | MIDDLE<br><i>E.</i>   |  | LAST<br><i>McCoy</i>  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><i>2 27 82</i>  |  | 2b. HOUR<br><i>9 30</i> P.M.                 |  |
| 3. SEX<br><i>Male</i>  |  | 4. RACE<br><i>Black</i>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><i>4 12 28</i>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><i>53</i>  |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS<br><i>YRS.</i>   |  | 7. IF UNDER 1 YEAR<br>HOURS MIN.             |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><i>N.C.</i>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><i>USA</i>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><i>City</i>   |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><i>Baltimore</i>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><i>John Deaton N/H</i> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)                                |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |  |  |
| 13a. STATE<br><i>MD</i>  |  | 13b. COUNTY<br><i>Baltimore</i>   |  | 13c. CITY OR TOWN<br><i>Baltimore</i>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><i>925 Bennett Place</i>  |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><i>Ralph McCoy</i>   |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><i>Flora</i>   |  |   |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <i>Yes</i>  |  |   |  | 16b. SOCIAL SECURITY NO.<br><i>245-22-4031</i>  |  | 17. INFORMANT ADDRESS<br><i>Lillie McCoy 925 Bennett Place</i>                                  |  |  |  |  |  |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>4254 Cardiac arrest / sepsis</i><br>DUE TO, OR AS A CONSEQUENCE OF (b) <i>Pulmonary edema</i><br>DUE TO, OR AS A CONSEQUENCE OF (c) <i>stroke Encephalopathy</i><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |   |  |   |  |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><i>Alzheimer's disease</i>   |  |   |  |   |  |   |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><i>P.M. 19</i>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |  |   |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>7-27</i> , 19 <i>81</i> , to <i>2-28</i> , 19 <i>82</i> , that (I) (we) last saw the deceased alive on <i>2-28</i> , 19 <i>82</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                   |  |   |  |   |  |   |  |  |  |  |  |
| 22b. PHYSICIAN'S NAME (TYPE OR PRINT)<br><i>M. Brown</i>   |  |   |  | 22c. DEGREE<br><i>MD</i>  |  |   |  | 22d. DATE SIGNED<br><i>2/28/82</i>   |  |  |  |
| 22e. ADDRESS<br><i>611 P. Charles Street</i>   |  |   |  |   |  |   |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><i>Burial</i>   |  | 23b. DATE<br><i>3/5/82</i>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><i>Mt. Auburn Cem.</i>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><i>Baltimore MD</i>                               |  |  |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><i>Wm. C. March F/H</i>  |  |   |  | ADDRESS<br><i>1101 E. North Ave.</i>  |  | 25a. DATE REC'D. BY REGISTRAR<br><i>MAR 1 1982</i>  |  | 25b. REGISTRAR'S SIGNATURE<br><i>Frances Jan. Winters</i>  |  |  |  |



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrars, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copiers. Pages 1 and 2 should be filed with the registrar after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified by item 14.

FOR  
1. STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

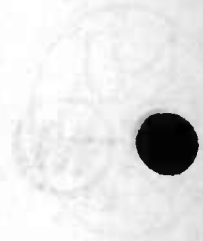
8 2 0 4 0 0 6

REG. NO.

|   |  |  |   |   |  |  |                                   |   |   |  |
|---|--|--|---|---|--|--|-----------------------------------|---|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>THOMAS McCray</b>  |  |  | 2a. DATE OF DEATH<br>MONTH <b>2</b> DAY <b>5</b> YEAR <b>82</b> |   |  | 2b. HOUR <b>5</b> PM   |                                   |   |   |  |
| 3. SEX<br><b>Male</b>   |  | 4. RACE<br><b>Negro</b>  |   | 5. DATE OF BIRTH<br>MONTH <b>7</b> DAY <b>11</b> YEAR <b>04</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>77</b> YRS.  |                                   |   |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>GA</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>S. Balt - City</b> MD   |                                   |   |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>S. BALT.</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>3001 S HANOVER ST SBGH</b> |   |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)   |                                   | 12b. KIND OF BUSINESS OR INDUSTRY   |   |  |
| 13a. STATE<br><b>md</b>   |  | 13b. COUNTY  |   | 13c. CITY OR TOWN<br><b>Balt.</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |                                   | 13e. STREET ADDRESS<br><b>734 Roundview</b>                                   |   |  |
| 14. FATHER'S NAME<br>FIRST <b>Jockey</b> MIDDLE <b>McCray</b> LAST <b>McCray</b>  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>Margaret</b> MIDDLE <b>Aske</b> LAST <b>Aske</b>  |   | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>yes</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>259-05-4569</b>   |                                   | 16c. INFORMANT<br><b>SALLIE M. PLUTMAN</b> ADDRESS<br><b>734 ROUNDVIEW RD</b> |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiorespiratory arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>Sepsis</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>Carcinoma of stomach</b><br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a):<br><b>Arteriosclerotic heart disease</b> |  |  |   |   |  |  |                                   |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |  |
| 19a. DATE OF OPERATION<br><b>2-2-82</b>   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>Intraabdominal Sepsis</b>   |   | 19c. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 19d. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                   |   |   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 20b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |   | 20c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART II)   |  |  |                                   |   |   |  |
| 21a. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK  |  | 21b. PLACE OF INJURY<br>(AT HOME-STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21c. LOCATION<br>(STREET) CITY OR TOWN COUNTY STATE   |  |  |                                   |   |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>12/29/81</b> , 19____, to <b>2/5/82</b> , 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |  |   |   |  |  |                                   |   |   |  |
| 22b. SIGNATURE<br><b>A. Zamudio</b>   |  | DEGREE<br><b>MD</b>  |   | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>                  |  |  | 22c. DATE SIGNED<br><b>2/5/82</b> |   |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>SANTIAGO ZAMUDIO</b>  |  |  |   | 22e. ADDRESS<br><b>3001 S HANOVER ST. BALT. MD 21230</b>  |  |  |                                   |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY) <b>BURIAL</b>  |  | 23b. DATE<br><b>2/11/82</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>MT. AUBURN</b>   |  | 23d. LOCATION<br>(CITY OR TOWN) COUNTY STATE<br><b>BALTIMORE MD</b>  |                                   |   |   |  |
| 24. FUNERAL DIRECTOR<br>NAME <b>WM. C. MARCH FUN'L HOME</b> ADDRESS <b>1101 E. NORTH</b>  |  |  |   | 25a. DATE REC'D. BY REGISTRAR<br><b>FEB 8 1982</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Frances Jan Nathan</b>  |                                   |   |   |  |

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| STATE OF MARYLAND   |  |  |  |  |  |   |                            |   |  |
|---|--|--|--|--|--|---|----------------------------|---|--|
| DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |  |  |  |  |   |                            |   |  |
| CERTIFICATE OF DEATH  |  |  |  |  |  |   |                            |   |  |
| REG. NO. 8 2 0 4 0 0 7  |  |  |  |  |  |   |                            |   |  |
| 1. FOR STATE REGISTRAR <b>Lessie M. McDaniel</b>  |  |  |  |  |  |   |                            |   |  |
| 1. DECEASED NAME (TYPE OR PRINT) <b>LESSIE M. McDaniel</b>  |  |  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR <b>02 15 82</b> |   | 2b. HOUR <b>10:00 P.M.</b> |   |  |
| 3. SEX <b>Female</b>  |  | 4. RACE <b>White</b>   |  | 5. DATE OF BIRTH MONTH DAY YEAR <b>Jan. 14 1919</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY) <b>63</b> YRS   |                            | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>North Carolina</b>   |  | 7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.  |                            |   |  |
| 10. CITY OR TOWN OF DEATH <b>Baltimore</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Bon Secours Hospital</b> |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>worker</b>   |                            | 12b. KIND OF BUSINESS OR INDUSTRY <b>cotton mill</b>  |  |
| 13a. STATE <b>Maryland</b>  |  | 13b. COUNTY <b>---(city)</b>   |  | 13c. CITY OR TOWN <b>Baltimore</b>   |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |                            | 13e. STREET ADDRESS <b>411 S. Parrish St. 21223</b>   |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST <b>Preston Duke Hopper</b>  |  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Lula May Carroll</b>   |  |   |                            |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>   |  |  |  | 16b. SOCIAL SECURITY NO. <b>223-26-6957</b>  |  | 17. INFORMANT ADDRESS <b>Samuel F McDaniel/411 S Parrish St/Balto Md 21223</b>  |                            |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac arrest</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Renal Failure</b> <b>Diabetes mellitus</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>5860</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost |  |  |  |  |  |   |                            |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>5860</b>  |  |  |  |  |  |   |                            |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>  |                            | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2)   |  |   |                            |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>09/01 81</b> <b>03/15 82</b>   |  | 22a. I certify that (I) (the hospital) attended the deceased from <b>02/19/82</b> 19 <b>82</b> , to <b>02/19/82</b> 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death. |                            |   |  |
| 22b. SIGNATURE <b>Kuang-Yen Huang</b> M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>   |  |  |  | 22c. DATE SIGNED <b>2/16/82</b>  |  | 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>KUANG-YEN HUANG</b>  |                            |   |  |
| 22e. ADDRESS <b>BON Secours Hospital</b>  |  |  |  | 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>  |  |   |                            |   |  |
| 23b. DATE <b>02/19/82</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY <b>Highland Burial Park</b>   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE <b>Danville/Pittsylvania/Virginia</b>  |  |   |                            |   |  |
| 24. FUNERAL DIRECTOR NAME <b>Walters Funeral Home/Pratt &amp; Stricker Streets</b> ADDRESS <b>Balto Md 21223</b>  |  |  |  | 25a. DATE REC'D. BY REGISTRAR <b>FEB 19 1982</b>   |  | 25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>   |                            |   |  |

34

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 4 0 0 8

REG. NO.

|  |  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  | FIRST MIDDLE LAST  |  | 2a. DATE OF DEATH MONTH DAY YEAR   |  | 2b. HOUR   |  |
| Aserlee  |  | O. McGlocklin  |  | 2-24-82  |  | 2:46P <sub>M</sub>   |  |
| 3. SEX   | 4. RACE  | 5. DATE OF BIRTH MONTH DAY YEAR  |  | 6. AGE (IN YEARS LAST BIRTHDAY)  |  | 7. IF UNDER 1 YEAR MONTHS DAYS                                 |  |
| Female   | Black  | 12 22 1915   |  | 66   |  | YRS.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  | 7b. CITIZEN OF WHAT COUNTRY?   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH   |  | 10. IF UNDER 24 HRS. HOURS MIN.                                |  |
| N.C.   | U.S.A.   |  |  | Baltimore City   |  | MD.  |  |
| 10. CITY OR TOWN OF DEATH  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                                |  | 12b. KIND OF BUSINESS OR INDUSTRY                              |  |
| Baltimore  | John Hopkins Hospital  |  |  | Housewife  |  |  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |  |  | 13b. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |  |
| 13a. STATE   |  | 13b. COUNTY  |  | 13c. CITY OR TOWN  |  | 13d. STREET ADDRESS  |  |
| Md.  |  |  |  | Balto  |  | 1717 Druid Lake Dr.  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST  |  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST   |  |  |  |
| Samuel Knotts  |  |  |  | Mattie Knotts  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)  |  | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT ADDRESS  |  |  |  |
| no   |  | 214 20 1821  |  | Major McGlocklin 2127 McCulloh St.   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |  |  |  |  |  |  |  |
| PART I. DEATH WAS CAUSED BY:   |  |  |  |  |  |  |  |
| IMMEDIATE CAUSE (a) <u>massive intracranial Hemorrhage</u>   |  |  |  |  |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF (b) <u>Dissecting aneurysm</u>  |  |  |  |  |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF (c) <u></u>   |  |  |  |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <u></u>   |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |  |
| 2/19/82  |  | Evacuation of Intestines   |  | NO <input type="checkbox"/>  |  | YES <input checked="" type="checkbox"/>                        |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)               |  |  |  |
|  |  | P.M. 19  |  |  |  |  |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |  |  |
|  |  |  |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>2/19/82</u> to <u>2/24/82</u> , that (I) (we) last saw the deceased alive on <u>2/24/82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. |  |  |  |  |  |  |  |
| 22b. SIGNATURE OF PHYSICIAN (TYPE OR PRINT) <u>Wm. J. Morton</u> DEGREE <u>MD</u> 22c. DATE SIGNED <u>2/24/82</u>  |  |  |  |  |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>J. A. Winfield</u> 22e. ADDRESS <u>Johns Hopkins Hospital</u>   |  |  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE                        |  |
| Burial   |  | 3/1/82   |  | King Mem. Park   |  | Randallstown, Md.  |  |
| 24. FUNERAL DIRECTOR NAME <u>Jas. A. Morton &amp; Sons</u> ADDRESS <u>1701 Laurens St.</u>   |  |  |  | 25a. DATE REC'D. BY REGISTRAR  |  | 25b. REGISTRAR'S SIGNATURE                                     |  |
|  |  |  |  | FEB 26 1982  |  | <u>Thomas J. Morton</u>  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

U.S. DEPARTMENT OF JUSTICE  
FEDERAL BUREAU OF INVESTIGATION  
WASHINGTON, D.C.

TO : DIRECTOR, FBI  
FROM : SAC, NEW YORK  
SUBJECT: [Illegible]  
RE: [Illegible]

Enclosed for the Bureau are two copies of a letterhead memorandum (LHM) dated and captioned as above. The LHM was prepared by the New York Office on [Illegible] and contains information regarding [Illegible].

The LHM was prepared by [Illegible] and contains information regarding [Illegible]. The information was obtained from [Illegible] and is being furnished to the Bureau for its information.

Very truly yours,  
[Illegible Signature]  
Special Agent in Charge



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

DHMH-16 50M 1/81  
(VRA 15, 4)

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  |   |  |  |  |   |   |  |  |
|---|--|--|--|---|--|--|--|---|---|--|--|
| 1. FOR STATE REGISTRAR  |  |  |  |   | REG. NO.   |  |  |   |   |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>HELENA LOUISE McGRAW</b>   |  |  |  |   | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>2 18 82</b> |  |  |   |   | 2b. HOUR<br><b>11:34<sup>P</sup></b>   |  |
| 1. SEX<br><b>FEMALE</b>   |  | 4. RACE<br><b>WHITE</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>02 19 24</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>57</b> YRS.                                    |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br><b>---</b>                                    |   | IF UNDER 24 HRS.<br>HOURS MIN.<br><b>---</b>   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MARYLAND</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.                    |  |   |   |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>ST. AGNES HOSPITAL -- E.R.</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>HOMEMAKER</b> |  |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>---</b> |  |  |
| 13a. STATE<br><b>MARYLAND</b>   |  |  |  |   |  |  |  |   |   |  |  |
| 13b. COUNTY<br><b>BALTIMORE</b>   |  | 13c. CITY OR TOWN<br><b>LANSOWNE</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 13e. STREET ADDRESS<br><b>49 CARLING CIRCLE, 21227</b>                               |  |   |   |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>UNKNOWN SHILLING</b>   |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>UNKNOWN</b>   |  |  |  |   |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>NO</b>   |  |  |  | 16b. SOCIAL SECURITY NO.<br><b>217-18-3519</b>  |  | 17. INFORMANT<br>ADDRESS<br><b>THOMAS A. McGRAW 49 CARLING CIRCLE</b>                |  |   |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Acute myocardial infarction</b><br>4100<br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>Coronary heart disease</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:<br>DUE TO, OR AS A CONSEQUENCE OF (c)<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a) |  |  |  |   |  |  |  |   |   |  |  |
| MEDICAL CERTIFICATION   |  |  |  |   |  |  |  |   |   |  |  |
| 19a. DATE OF OPERATION  |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>       |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |  |   |   |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |   |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____ 19____ to _____ 19____, that (I) (we) last saw the deceased alive on _____ 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.  |  |  |  |   |  |  |  |   |   |  |  |
| 22b. SIGNATURE<br><b>Sujeta Sapsiri, M.D.</b>   |  |  |  | DEGREE<br><b>M.D.</b>   |  |  |  | 22c. DATE SIGNED<br><b>2-19-82</b>  |   |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>SUJETA SAPSIRI, M.D.</b>  |  |  |  | 22e. ADDRESS<br><b>1910-14 W. PRATT STREET</b>  |  |  |  |   |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>   |  |  |  | 23b. DATE<br><b>02-22-82</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>CEDAR HILL</b>                              |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>BROOKLYN PK. A.A. MARYLAND</b> |   |  |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>HUBBARD FUNERAL HOME, INC. 4107 WILKENS AVE.</b>   |  |  |  | 24b. CITY OR TOWN<br><b>21229</b>   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>FEB 22 1982</b>                                  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Thomas J. [Signature]</b>                      |   |  |  |



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 4 0 1 0

FOR  
STATE  
REGISTRAR

REG. NO.

|   |   |  |  |   |                                   |
|---|---|--|--|---|-----------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Edward Andrew McGuire</b>  |   |  | 2a. DATE OF DEATH <b>2 20 82</b> 11:45 AM  |   |                                   |
| 3. SEX<br><b>Male</b>   | 4. RACE<br><b>Black</b>   | 5. DATE OF BIRTH<br><b>8 28 31</b>   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>50</b>   |   |                                   |
| 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Pennsylvania</b>   | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S. USA</b>   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>                    | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City MD.</b>                    |   |                                   |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   | 11. NAME OF HOSPITAL NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE RESIDENCE BEFORE ADMISSION)<br><b>Good Samaritan Hosp.</b> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Printer</b>   |   | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13b. STATE <b>Md.</b> COUNTY <b>Howard</b>  |   | 13c. CITY <b>Columbia</b>  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |                                   |
| 14. FATHER'S NAME<br>FIRST <b>Earl</b> MIDDLE <b>McGuire</b> LAST <b>McGuire</b>  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>Mary</b> MIDDLE <b>Smoot</b> LAST <b>Smoot</b>  |  |   |                                   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>No</b>  |   | 16b. SOCIAL SECURITY NUMBER<br><b>198-24-2434</b>  |  | 17. INFORMANT<br><b>George A. Warden Funeral Home</b>                     |                                   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Metastatic Carcinoma of Lung</b><br>1629<br>DUE TO, OR AS A CONSEQUENCE OF (b) _____<br>DUE TO, OR AS A CONSEQUENCE OF (c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |   |  |  |   |                                   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a  |   |  |  |   |                                   |
| 19a. DATE OF OPERATION  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                                   |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |   | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                          |  |   |                                   |
| 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18; PART 1 OR PART 2)   |  |   |                                   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                         |                                   |
| 22a. I certify that I (1) (that hospital) attended the deceased from <b>Feb 11 1982</b> to <b>Feb 20 1982</b> that (1) (we) last saw the deceased live on <b>Feb 20 1982</b> and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did not) view the body after death.   |   |  |  |   |                                   |
| 22b. SIGNATURE<br><b>Charles Padgett</b>  |   | DEGREE <b>MD</b><br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL <input type="checkbox"/> STAFF <input type="checkbox"/> PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br><b>2/21/82</b>  |                                   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>CHARLES PADGETT</b>   |   | 22e. ADDRESS<br><b>5601 Loch Raven Blvd, Baltimore</b>   |  |   |                                   |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |   | 23b. DATE<br><b>2/25/82</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Calvary Cemetery</b>             |                                   |
| 23d. LOCATION<br>CITY OR TOWN<br><b>Pittsburgh</b>  |   | COUNTY <b>Allegheny</b> STATE <b>Pa.</b>   |  |   |                                   |
| 24. FUNERAL DIRECTOR<br>NAME <b>Witzke P.A.</b> ADDRESS <b>1630 Edmondson Avenue, Catonsville, Md.</b>  |   | 25a. DATE REC'D. BY REGISTRAR<br><b>FEB 22 1982</b>  |  |   |                                   |

1. The medical examiner must be notified of the death of a person who has been killed by a motor vehicle, aircraft, or other means of transportation, or who has died as a result of a fire, explosion, or other disaster, or who has died as a result of a violent or unusual death, or who has died as a result of a disease or condition which is unusual or unusual for the age of the person.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, THE EXAMINER SHOULD WRITE "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL HOME. GIVE PAGE 4 TO THE MEDICAL EXAMINER. RETAIN PAGE 5 FOR VITAL RECORDS. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITH VITAL RECORDS. AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP  
DHMH-17  
(VR A15 ME (5))  
15M 2/80

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

|   |  |   |   |   |  |
|---|--|---|---|---|--|
| 1- FOR STATE REGISTRAR  |  | 2a. DATE KNOWN OF DEATH   |   | 2b. HOUR  |  |
| 1. DECEASED NAME (TYPE OR PRINT)  |  | 2c. DATE PRONOUNCED DEAD  |   | 2d. HOUR  |  |
| HENDERSON   |  | 2-19-82   |   | 9:40A   |  |
| 3. SEX  | 4. RACE  | 5. DATE OF BIRTH  | 6. AGE (IN YEARS)   | 7. IF UNDER 1 YR.   | 7. IF UNDER 24 HRS.                          |
| male  | black  | 3 13 38   | 43 YRS.   |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   | 7b. CITIZEN OF WHAT COUNTRY?                             | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |   |  |
| S.C.  | USA  | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>                    | Baltimore City  |   |  |
| 10. CITY OR TOWN OF DEATH   | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                         |   | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| Baltimore   | Bon Secour Hospital                                      |   |   |   |  |
| 13a. STATE  | 13b. COUNTY  | 13c. CITY OR TOWN   | 13d. INSIDE CITY LIMITS?  | 13e. STREET ADDRESS   |  |
| MD  |  | Baltimore   | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 1105 Darley Avenue  |  |
| 14. FATHER'S NAME   | 15. MOTHER'S MAIDEN NAME                                 | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?  |   |   |  |
|   | Inez   | 16b. SOCIAL SECURITY NO.  |   |   |  |
|   |  | 250-62-0551   |   |   |  |
| 17. INFORMANT   |  | ADDRESS   |   |   |  |
| Martha McInnis  |  | 1105 Darley Avenue  |   |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |  |   |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART I DEATH WAS CAUSED BY:   |  |   |   |   |  |
| IMMEDIATE CAUSE (a) Multiple gunshot wounds   |  |   |   |   |  |
| DUE TO, OR AS A CONSEQUENCE OF  |  |   |   |   |  |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.   |  |   |   |   |  |
| (b)   |  |   |   |   |  |
| DUE TO, OR AS A CONSEQUENCE OF  |  |   |   |   |  |
| (c)   |  |   |   |   |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |   |   |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                                     |   | 20. AUTOPSY?  |  |
|   |  |   |   | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>           |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  | 21b. TIME OF INJURY   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |  |
|   |  | 9:10AM 2-19-82  |   | subject shot  |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)                           |   | 21f. LOCATION   |  |
| A&P store   |  |   |   | 2401 Frederick Avenue Balto., Maryland  |  |
| 22a. I certify that I took charge of the remains described above, held on   |  |   |   |   |  |
| Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion  |  |   |   |   |  |
| death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> . |  |   |   |   |  |
| ACTUAL SIGNATURE  |  | TITLE (SPECIFY)   |   | DATE SIGNED   |  |
| Margarita A. Koroll, M.D.   |  | M.D. Assistant  |   | 2-19-82   |  |
| EXAMINER'S NAME (TYPE OR PRINT)   |  | ADDRESS   |   |   |  |
| Margarita A. Koroll, M.D.   |  | 111 Penn Street   |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   | 23b. DATE  | 23c. NAME OF CEMETERY OR CREMATORY  | 23d. LOCATION   | COUNTY  | STATE  |
| Burial  | 2/25/82  | Church Cemetery   | Clio  | S.C.  |  |
| 24. FUNERAL DIRECTOR  |  | 25a. DATE REC'D. BY REGISTRAR   |   | 25b. REGISTRAR'S SIGNATURE  |  |
| Wm. C. March F/H  |  | FEB 23 1982   |   | Thomas J. [Signature]   |  |
| NAME  |  | ADDRESS   |   |   |  |
| 1101 E. North Ave.  |  |   |   |   |  |

0908

(15)

BOX COTTON TIE

WEEKLY BIRTH

1913

W. H. H. H. H.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |   | REG. NO.   |  |
|--|--|--|--|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>JOHN L. MCKENZIE</b>  |  |  | 2a. DATE OF DEATH<br>MONTH <b>02</b> DAY <b>16</b> YEAR <b>82</b>                  |   | 2b. HOUR<br><b>7:45 AM</b>                                       |  |
| 3. SEX<br><b>male</b>  |  | 4. RACE<br><b>black</b>  |  | 5. DATE OF BIRTH<br>MONTH <b>3</b> DAY <b>3</b> YEAR <b>1911</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>70</b> YRS   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>S. C.</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore city</b> MD.  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>2045 Braddish Avenue</b> |  |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE) |  |
| 12b. KIND OF BUSINESS OR INDUSTRY  |  | 13a. STREET ADDRESS<br><b>2045 Braddish Avenue</b>   |  | 13b. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |  |
| 13c. CITY OR TOWN<br><b>Baltimore</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 13e. STREET ADDRESS<br><b>2045 Braddish Avenue</b>  |  |  |
| 14. FATHER'S NAME<br>FIRST <b>Henry</b> MIDDLE <b>McKenzie</b> LAST <b>McKenzie</b>  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>Rosa</b> MIDDLE <b>Lee</b> LAST <b>Gamble</b> |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>No</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>247-10-4244</b>   |  | 17. INFORMANT'S ADDRESS<br><b>Maude McKenzie 2045 Braddish Avenue</b>   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiac arrest</b><br><b>4349</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>multiple cerebral infarction</b><br>(c) <b>Lung tumor</b>                   |  |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: ( )   |  |  |  |   |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>1/11</b> 19 <b>81</b> to <b>2/16</b> 19 <b>82</b> , that (I) (we) last saw the deceased alive on <b>2/2/82</b> 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  | 22b. SIGNATURE<br><b>Kuang-Yen Huang</b>   |  | DEGREE<br><b>M.D.</b>   |  | 22c. DATE SIGNED<br><b>2/16/82</b>   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>KUANG-YEN HUANG</b>  |  | 22e. ADDRESS<br><b>BON Secours Hospital</b>  |  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>2/20/82</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Baltimore Cemetery</b>   |  | 23d. LOCATION<br>Baltimore COUNTY MD STATE   |
| 24. FUNERAL DIRECTOR<br><b>William C. March F/H</b>  |  |  |  | 25a. DATE RECEIVED BY REGISTRAR<br><b>FEB 17 1982</b>   |  |  |
| ADDRESS<br><b>1101 E. North Avenue</b>   |  |  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Thane J. [Signature]</b>   |  |  |



1877

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR RECORDS. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP  
DHMH-17  
(VRA15 ME (1))  
15M 2/80

| FOR STATE REGISTRAR   |  |               |  |   |  |  |  |  |  | STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH |  |   |  |  |  |                                      |  |  |  | REG. NO. 2 0 4 0 1 3 |  |
|---|--|---------------|--|---|--|--|--|--|--|---|--|---|--|--|--|--------------------------------------|--|--|--|----------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) Mae Bell Mc Neil  |  |               |  |   |  |  |  |  |  | 2a. DATE KNOWN OF DEATH<br>ESTI MATED xx 2 13 19 82   |  |   |  |  |  |                                      |  |  |  | 2b. HOUR 1:40 PM     |  |
| 3. SEX female   |  | 4. RACE black |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR 6 2 1928   |  | 6. AGE (IN YEARS LAST BIRTHDAY) 53 YRS.            |  | IF UNDER 1 YR. MONTHS DAYS   |  | IF UNDER 24 HRS. HOURS MIN.   |  | 2c. DATE PRONOUNCED DEAD 2 15, 82 1:40 PM               |  |  |  |                                      |  |  |  |                      |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) N.C.  |  |               |  | 7b. CITIZEN OF WHAT COUNTRY? USA  |  |  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |  |   |  | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD. |  |  |  |                                      |  |  |  |                      |  |
| 10. CITY OR TOWN OF DEATH Baltimore   |  |               |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1833 Vine Street |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Disabled   |  |   |  | 12b. KIND OF BUSINESS OR INDUSTRY                       |  |  |  |                                      |  |  |  |                      |  |
| 13a. STATE Md   |  |               |  |   |  |  |  |  |  | 13b. COUNTY Balto   |  | 13c. CITY OR TOWN Balto                                 |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS 1833 Vine Street |  |  |  |                      |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST Lonnie McClain   |  |               |  |   |  |  |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST Mozelle Buffaleo  |  |   |  |  |  |                                      |  |  |  |                      |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN) No  |  |               |  | 16b. SOCIAL SECURITY NO. 243 32 4212  |  |  |  | 17. INFORMANT ADDRESS Annie McClain 5 N. Payson Street   |  |   |  |   |  |  |  |                                      |  |  |  |                      |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>4292 IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardiovascular disease</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH              |  |               |  |   |  |  |  |  |  |   |  |   |  |  |  |                                      |  |  |  |                      |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).   |  |               |  |   |  |  |  |  |  |   |  |   |  |  |  |                                      |  |  |  |                      |  |
| 19a. DATE OF OPERATION  |  |               |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  |  |  |  |  |   |  |   |  | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>             |  |                                      |  |  |  |                      |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |  |               |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR P.M. 19   |  |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)  |  |   |  |   |  |  |  |                                      |  |  |  |                      |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |               |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)   |  |  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |   |  |   |  |  |  |                                      |  |  |  |                      |  |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: <u>natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |  |               |  |   |  |  |  |  |  |   |  |   |  |  |  |                                      |  |  |  |                      |  |
| ACTUAL SIGNATURE <u>H.R. Guard</u>  |  |               |  | TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER   |  |  |  |  |  |   |  |   |  | DATE SIGNED 2/16/82  |  |                                      |  |  |  |                      |  |
| EXAMINER'S NAME (TYPE OR PRINT) Hormez R. Guard, M.D.   |  |               |  | ADDRESS 111 Penn Street, Balto, MD 21201  |  |  |  |  |  |   |  |   |  |  |  |                                      |  |  |  |                      |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial  |  |               |  | 23b. DATE 2-22-82   |  | 23c. NAME OF CEMETERY OR CREMATORY Mt. Auburn Cem. |  |  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE Baltimore MD.  |  |   |  |  |  |                                      |  |  |  |                      |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS Brown/Thompson F.H. 1913 W. Balto. St.   |  |               |  |   |  |  |  |  |  | 25a. DATE REC'D. BY REGISTRAR 19 REGISTRAR <u>Frances</u>   |  |   |  |  |  |                                      |  |  |  |                      |  |

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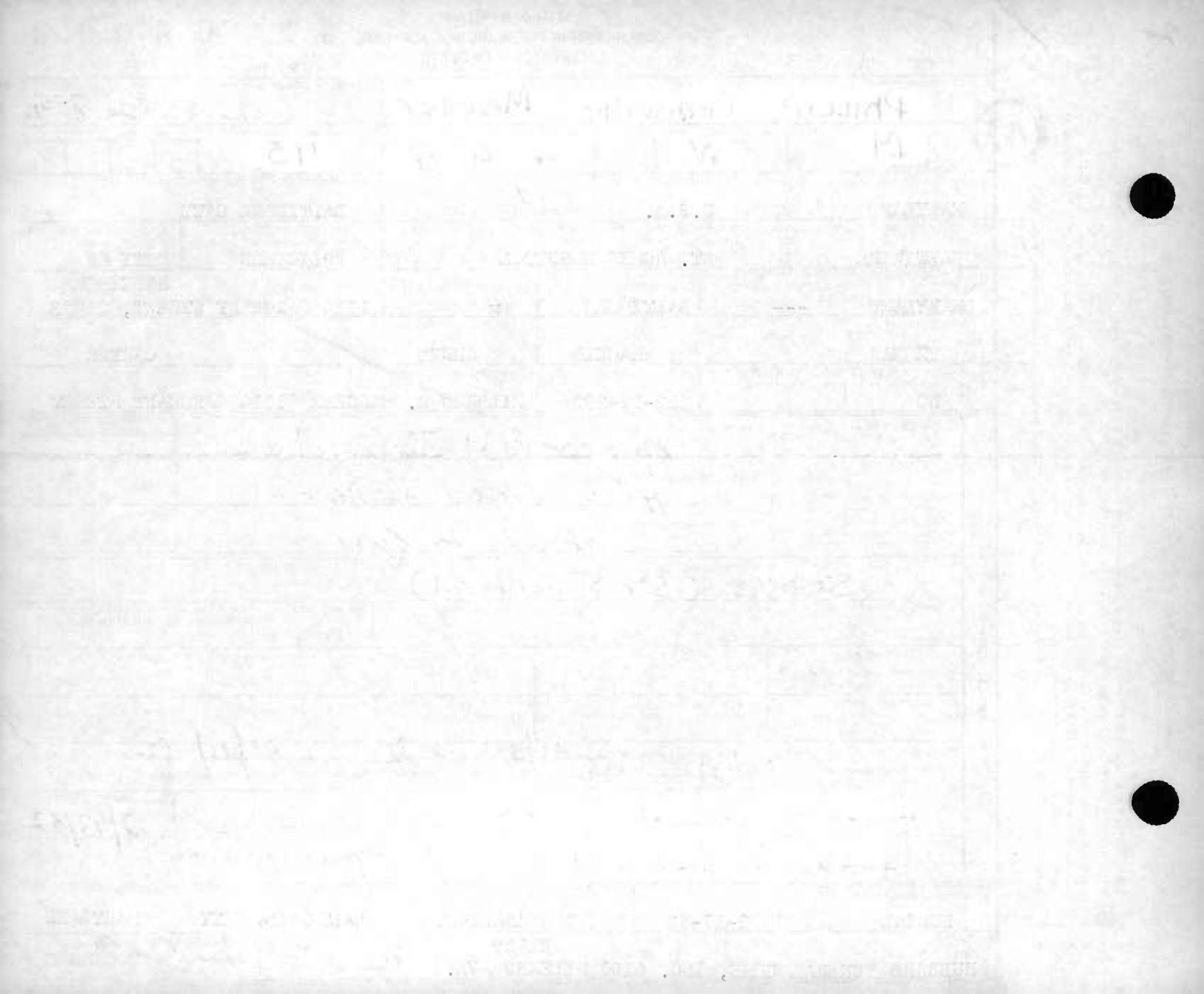
Jan 21/11

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

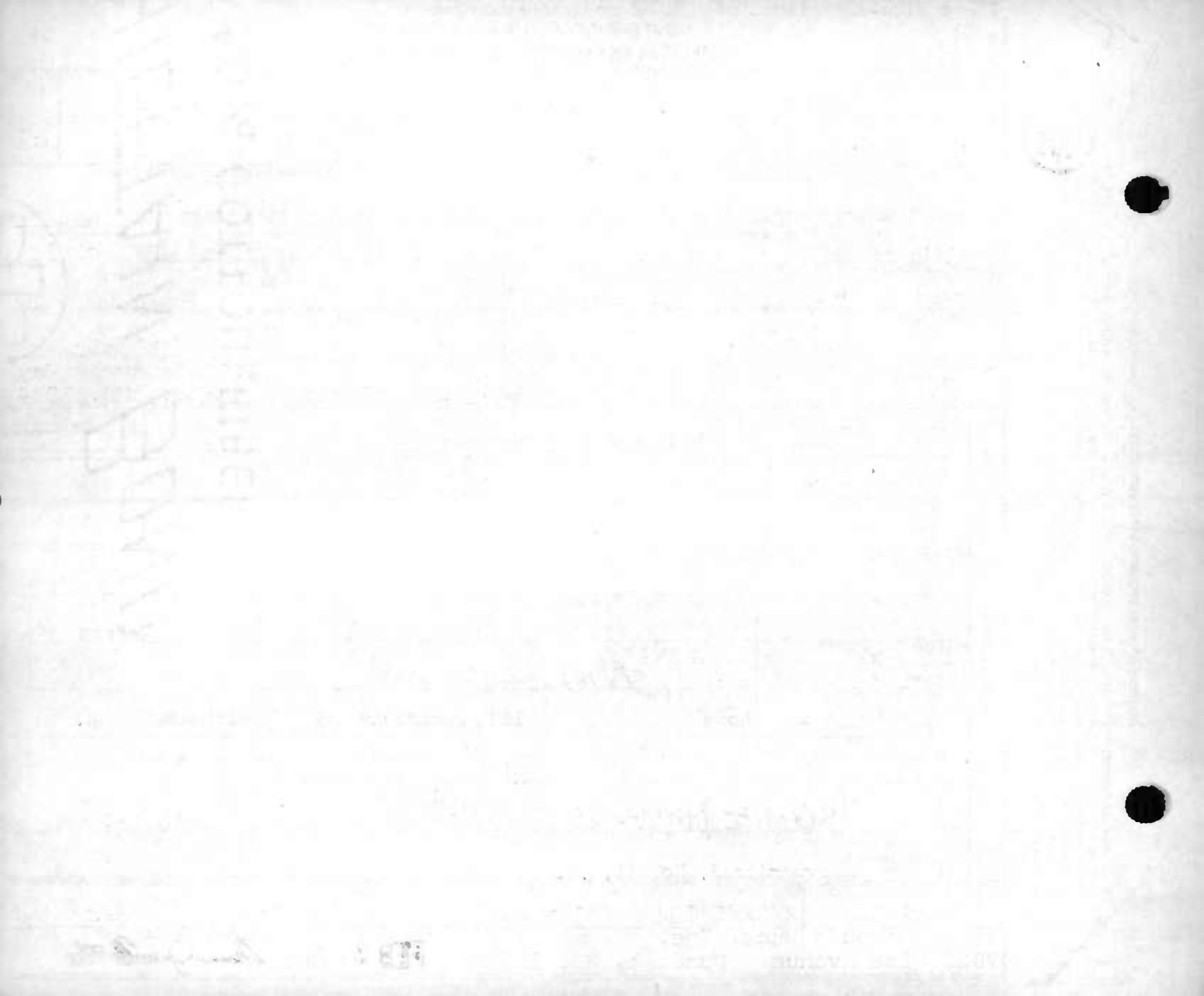
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at 301-333-1234.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  |  |  |  |  |  |  | REG. NO.   |  |
|---|--|--|--|--|--|--|--|--|--|--|--|
| 1 - FOR STATE REGISTRAR   |  |  |  |  |  | 8204014  |  |  |  |  |  |
| 1 DECEASED NAME FIRST MIDDLE LAST<br><b>PHILIP G. MEAGHER</b>   |  |  |  |  |  | 2a DATE OF DEATH MONTH DAY YEAR<br><b>2 13 82</b>  |  |  |  |  |  |
| 3 SEX<br><b>MALE</b>  |  |  |  |  |  | 4 RACE<br><b>WHITE</b>   |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>04 09 08</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>73</b> YRS.  |  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MARYLAND</b>   |  |  |  |  |  | 7b CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.   |  |
| 10 CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>  |  |  |  |  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>ST. AGNES HOSPITAL</b> |  |  |  | 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>POLICEMAN</b>  |  |
| 12b KIND OF BUSINESS OR INDUSTRY<br><b>CITY OF</b>  |  |  |  |  |  |  |  |  |  |  |  |
| 13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>STATE<br><b>MARYLAND</b>   |  |  |  |  |  | 13b COUNTY<br><b>---</b>   |  | 13c CITY OR TOWN<br><b>BALTIMORE</b>   |  | 13d INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                             |  |
| 14 FATHER'S NAME FIRST MIDDLE LAST<br><b>THOMAS MEAGHER</b>   |  |  |  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>ANNIE CARTER</b>  |  |  |  |  |  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>NO</b>  |  |  |  |  |  | 16b SOCIAL SECURITY NO.<br><b>212-09-2986</b>  |  | 17 INFORMANT ADDRESS<br><b>MILDRED E. MEAGHER 1114 SARGEANT STREET</b>   |  |  |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Myocardial Infarction</b><br><b>5860</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>High degree AV Block</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Renal Failure</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. |  |  |  |  |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a)<br><b>Sepsis (Staphylococcal)</b>   |  |  |  |  |  |  |  |  |  |  |  |
| 19a DATE OF OPERATION   |  |  |  | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED                        |  |  |  | 20a AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>      |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)   |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>01/30/82</b> to <b>02/13/82</b> that (I) (we) lost saw the deceased alive on <b>02/13/82</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |  |  |  |  |  |  |  |  |  |  |
| 22b. SIGNATURE<br><b>A. N. Samuel</b>   |  |  |  |  |  | DEGREE<br><b>M.D.</b>  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                 |  | 22c. DATE SIGNED<br><b>2/13/82</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>AMAR N. SARWAL</b>  |  |  |  |  |  | 22e. ADDRESS<br><b>St. Agnes Hospital</b>  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>BURIAL</b>  |  |  |  | 23b. DATE<br><b>02-17-82</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>NEW CATHEDRAL</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>BALTIMORE CITY MARYLAND</b>   |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>HUBBARD FUNERAL HOME, INC.</b>   |  |  |  |  |  | ADDRESS<br><b>4107 WILKENS AVE.</b>  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>FEB 16 1982</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><i>Thomas J. ...</i>   |  |



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR THE FUNERAL DIRECTOR. PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITH THE AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| 1- STATE REGISTRAR   |  |                         |  |   |  |   |  |   |  |   |  | REG. NO.   |  |  |  |  |  |  |  |
|--|--|-------------------------|--|---|--|---|--|---|--|---|--|--|--|--|--|--|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br><b>HERBERT C. MELCHIOR</b>   |  |                         |  |   |  |   |  |   |  |   |  | 2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR<br><b>2-18-82</b> |  |  |  | 2b. HOUR<br><b>1:39 P.M.</b>                             |  |  |  |
| 3. SEX<br><b>male</b>  |  | 4. RACE<br><b>white</b> |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>3 25 37</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>44 YRS.</b>                 |  | IF UNDER 1 YR. MONTHS DAYS  |  | IF UNDER 24 HRS. HOURS MIN.                           |  | 2c. DATE PRONOUNCED DEAD<br><b>2-18-82</b>   |  |  |  | 2d. HOUR<br><b>1:39 P.M.</b>                             |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   |  |                         |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  |   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |   |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b>  |  |  |  | MD.  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |  |                         |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>1231 Demarcay Way</b> |  |   |  |   |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Electrician</b>                    |  |  |  | 12b. KIND OF BUSINESS<br><b>Schroeder Electric</b>       |  |  |  |
| 13a. STATE<br><b>Maryland</b>  |  |                         |  | 13b. COUNTY<br><input checked="" type="checkbox"/>  |  | 13c. CITY OR TOWN<br><b>Baltimore</b>                             |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 13e. STREET ADDRESS<br><b>1231 Demarcay Way</b>       |  |  |  |  |  |  |  |  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>Not Known</b>  |  |                         |  |   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Anna Whealty</b> |  |   |  |   |  |  |  |  |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)<br><b>No</b>  |  |                         |  | 16b. SOCIAL SECURITY NO.<br><b>212-36-0961</b>  |  | 17. INFORMANT<br><b>Jo Ann Melchior</b>                           |  |   |  | ADDRESS<br><b>1231 Demarcay Way Balto., MD. 21224</b> |  |  |  |  |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Multiple drug overdose</b><br><b>9505</b><br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>DUE TO, OR AS A CONSEQUENCE OF  |  |                         |  |   |  |   |  |   |  |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |  |  |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).  |  |                         |  |   |  |   |  |   |  |   |  |  |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  |                         |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  |   |  |   |  |   |  | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                    |  |  |  |  |  |  |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |  |                         |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>? P.M. 2/18/82</b>   |  |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)<br><b>self/ingested</b>   |  |   |  |  |  |  |  |  |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK   |  |                         |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)<br><b>home</b>  |  |   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE<br><b>1231 Demarcay Way Baltimore Md.</b>  |  |   |  |  |  |  |  |  |  |  |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |  |                         |  |   |  |   |  |   |  |   |  |  |  |  |  |  |  |  |  |
| ACTUAL SIGNATURE<br><i>Margarita A. Korell</i>   |  |                         |  | TITLE (SPECIFY)<br><b>Assistant</b>   |  |   |  | MEDICAL EXAMINER  |  |   |  | DATE SIGNED<br><b>2-19-82</b>  |  |  |  |  |  |  |  |
| EXAMINER'S NAME (TYPE OR PRINT)<br><b>Margarita A. Korell, M.D.</b>  |  |                         |  | ADDRESS<br><b>111 Penn Street</b>   |  |   |  |   |  |   |  |  |  |  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |  |                         |  | 23b. DATE<br><b>2/22/1982</b>   |  |   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Holly Hill</b>   |  |   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>White Marsh Baltimore Maryland</b>                       |  |  |  |  |  |  |  |
| 24. FUNERAL DIRECTOR NAME<br><b>Duda-Ruck, Inc.</b>  |  |                         |  |   |  |   |  | ADDRESS<br><b>7922 Wise Avenue Dundalk, MD. 21222</b>   |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>FEB 23 1982</b>  |  |  |  | 25b. REGISTRAR'S SIGNATURE<br><i>John J. [Signature]</i> |  |  |  |





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at 1-800-371-3535.

FOR  
1- STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 4 0 1 6

REG. NO.

|  |  |  |   |  |  |
|--|--|--|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Robert E. Melton  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>2 27 82                                |  | 2b. HOUR<br>7:25 AM  |
| 3. SEX<br>M  | 4. RACE<br>N   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>03 15 38   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>43 YRS.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>North Carolina  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.                           |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Mercy |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Carpenter |  | 12b. KIND OF BUSINESS OR INDUSTRY  |
| 13a. STATE<br>Md.  |  |  | 13b. COUNTY<br>-  | 13c. CITY OR TOWN<br>Baltimore   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Robert   |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Sarah Morgan                 |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>242-54-4564   |   | 17. INFORMANT<br>ADDRESS<br>Willie Melton 2900 Hillsdale Ave.                        |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u><br>4466<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Thrombotic Thrombocytopenia Purpura</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH                       |  |  |   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)<br><u>Acute Renal Failure</u>   |  |  |   |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |   | 21c. HOW INJURY OCCURRED<br>(ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)    |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |
| 22a. I certify that (I) <u>this hospital</u> attended the deceased from <u>2/22</u> , 19 <u>82</u> , to <u>2/27</u> , 19 <u>82</u> , that (I) <u>we</u> last saw the deceased alive on <u>2/27</u> , 19 <u>82</u> , and that in (my) <u>our</u> opinion death occurred on the date and hour and from the causes stated above, (I) <u>do</u> (did not) view the body after death. |  |  |   |  |  |
| 22b. SIGNATURE<br><u>Edward C. Watters III</u>   |  | DEGREE<br>M.D.   |   | 22c. DATE SIGNED<br>2/27/82  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>Edward C. Watters III</u>  |  | 22e. ADDRESS<br><u>Mercy Hospital</u>  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial   | 23b. DATE<br>3/6/82  | 23c. NAME OF CEMETERY OR CREMATORY<br>Rest Heaven  |   | 23d. LOCATION<br>CITY OR TOWN<br>Wilson  | COUNTY STATE<br>N.C.   |
| 24. FUNERAL DIRECTOR<br>NAME<br>Wm. C. March F/H   |  | ADDRESS<br>1101 E. North Ave.  |   | 25a. DATE REC'D. BY REGISTRAR<br>MAR 1 1982  | 25b. REGISTRAR'S SIGNATURE<br><u>Frances Jean Watters</u>  |

APR 19 1964

UNITED STATES DEPARTMENT OF THE INTERIOR

BUREAU OF LAND MANAGEMENT



TO: Mr. A. J. [illegible]  
FROM: Mr. [illegible]  
SUBJECT: [illegible]

Re: [illegible]  
[illegible]

Enclosed for you are [illegible]  
[illegible]

I am sure you will find this information [illegible]  
[illegible]

Very truly yours,  
[illegible]

cc: [illegible]  
[illegible]

Very truly yours,  
[illegible]

cc: [illegible]  
[illegible]

Very truly yours,  
[illegible]

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 3 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH-17  
(VR A15 ME (5))  
15M 2/80

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

|  |                         |  |   |   |  |  |                       |  |
|--|-------------------------|--|---|---|--|--|-----------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>EDGAR E. MERCER</b>   |                         |  | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> ESTIMATED <input type="checkbox"/> <b>2-19-82</b> |   |  | 2b. HOUR <b>10:30</b>  |                       |  |
| 3. SEX<br><b>male</b>  | 4. RACE<br><b>white</b> | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>May 22, 1934</b>  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>47</b> YRS.   | IF UNDER 1 YR.<br>MONTHS DAYS HOURS MIN.  | IF UNDER 24 HRS.                                     | 7c. DATE PRONOUNCED DEAD<br><b>2-19-82</b>   | 7d. HOUR <b>10:30</b> |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   |                         | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b>  |                       |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |                         | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET-ADDRESS)<br><b>3411 Bateman Avenue</b> |   |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Truck Driver C. Hoffberger Co.</b> |                       | 12b. KIND OF BUSINESS OR INDUSTRY            |
| 13a. STATE<br><b>Maryland</b>  |                         | 13b. COUNTY<br><b>Carroll</b>  | 13c. CITY OR TOWN<br><b>Finksburg</b>   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   | 13e. STREET ADDRESS<br><b>2012 Arabian Dr. 21048</b> |  |                       |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>James F. McCabe</b>   |                         |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Hazel May Sanner</b>  |  |  |                       |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, YES, OR UNKNOWN)<br><b>Yes</b>   |                         | (IF YES, GIVE WAR OR DATES)<br><b>Korean</b>   |   | 16b. SOCIAL SECURITY NO.<br><b>215-32-8949</b>  |  | 17. INFORMANT <b>Mrs. Diana Mercer</b> ADDRESS <b>2012 Arabian Dr. Finksburg, Md. 21048</b>            |                       |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br><b>9654 IMMEDIATE CAUSE (a) Gunshot wound of chest</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____  |                         |  |   |   |  |  |                       | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1   |                         |  |   |   |  |  |                       |  |
| 19a. DATE OF OPERATION   |                         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |   |   |  | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                    |                       |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |                         | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>10:10AM 2-19-82</b>  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)<br><b>subject shot</b>  |  |  |                       |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |                         | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)<br><b>front lawn</b>   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br><b>3411 Bateman Avenue Baltimore, Maryland</b>   |  |  |                       |  |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> |                         |  |   |   |  |  |                       |  |
| ACTUAL SIGNATURE<br><b>Margarete A. Koroll</b>   |                         | TITLE (SPECIFY)<br><b>M.D. Assistant</b>   |   | MEDICAL EXAMINER  |  | DATE SIGNED <b>2-19-82</b>   |                       |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)<br><b>Margareta A. Koroll, M.D.</b>   |                         | ADDRESS <b>111 Penn Street</b>   |   |   |  |  |                       |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Entombment</b>   |                         | 23b. DATE<br><b>2-23-82</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Druid Ridge Mausoleum</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Pikesville Baltimore Maryland</b>                     |                       |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Loring Byers Funeral Directors Inc. 8728 Liberty Road Randallstown, Maryland 21133</b>  |                         |  |   | 25a. DATE RECD. BY REGISTRAR<br><b>FEB 22 1982</b>  |  |  |                       |  |



2000 CO. MILLER  
12/1/00

Mr. H. A. [unclear]

1000 [unclear] 12/1/00

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  |   |  |  |  |   |                                    | REG. NO. 8 2 0 4 0 1 8   |  |
|---|--|--|--|---|--|--|--|---|------------------------------------|--|--|
| 1. DECEASED NAME (TYPE OR PRINT)<br>MARIE MARGARET MEYER  |  |  |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>Feb. 13, 1982  |  |   |                                    | 2b. HOUR<br>6:30 P.M.  |  |
| 3. SEX<br>Female  |  | 4. RACE<br>White   |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>Feb. 13, 1894  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>88 YRS.   |  | IF UNDER 1 YEAR<br>MONTHS DAYS  |                                    | IF UNDER 74 HRS<br>HOURS MIN.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Germany  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U. S.  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.   |  |   |                                    |  |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>4138 DORIS AVE., BROOKLYN |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Nurse  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>self employee  |                                    |  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>New Jersey   |  |  |  |   |  | 13b. CITY OR TOWN<br>Essex Co  |  | 13c. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                    | 13d. STREET ADDRESS<br>Apt. 103<br>Thirty Gates Ave.   |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>Johannes Meyer   |  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Bertha Windsemburg  |  |  |  |   |                                    |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>NO  |  |  |  | 16b. SOCIAL SECURITY NO.<br>143 26 2910   |  | 17. INFORMANT<br>John Meyer 4138 Doris Ave. Balto. Md.   |  |   |                                    | ADDRESS<br>21225   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Candida - Resp. arrest</u><br><u>1890</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <u>Respiratory failure, etc.</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>Aspirin</u> |  |  |  |   |  |  |  |   |                                    | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)  |  |  |  |   |  |  |  |   |                                    |  |  |
| 19a. DATE OF OPERATION  |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |                                    | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |   |                                    |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET<br>CITY OR TOWN<br>COUNTY<br>STATE   |  |   |                                    |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>2/13/82</u> to <u>2/15/82</u> , that (I) (we) lost<br>saw the deceased alive on <u>2/15/82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.  |  |  |  |   |  |  |  |   |                                    |  |  |
| 22b. SIGNATURE<br><u>C. N. Batlingburg Sr.</u>  |  |  |  |   |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  |   | 22c. DATE SIGNED<br><u>2/15/82</u> |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>C. N. Batlingburg Sr.</u>   |  |  |  |   |  | 22e. ADDRESS<br><u>403 E. Patapsco 21225</u>   |  |   |                                    |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Cremation  |  |  |  | 23b. DATE<br>2/15/82  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Westview Mem Park  |  | 23d. LOCATION<br>CITY OR TOWN<br>COUNTY<br>STATE<br>Baltimore, Maryland                         |                                    |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>George J. Gonce, 4001 Ritchie Hgw., Baltimore   |  |  |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br>FEB 16 1982   |  | 25b. REGISTRAR'S SIGNATURE<br><u>[Signature]</u>  |                                    |  |  |



New Jersey, Office of the Attorney General  
Newark, New Jersey  
January 19, 1938  
Honorable John J. Connelley  
Newark, New Jersey  
Dear Mr. Connelley:

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of 6 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR  
1 - STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 4 0 1 9

REG. NO.

|   |  |  |  |   |   |   |   |
|---|--|--|--|---|---|---|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>Leo D Mika</b>   |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>2 1 82</b> |   |   | 2b. HOUR<br>M<br><b>11</b>  |   |
| 3. SEX<br><b>male</b>   |  | 4. RACE<br><b>white</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>1 9 05</b>   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>77</b> YRS.   |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.                               |   |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>6707 Gary Avenue</b> |  |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Inspector</b>            |   |
| 13a. STATE<br><b>Maryland</b>   |  | 13b. COUNTY  |  | 13c. CITY OR TOWN<br><b>Baltimore</b>   |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>John Mika</b>  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>unknown</b>  |  |   |   |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>no</b>   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>216 01 2034</b>  |  | 17. INFORMANT<br>ADDRESS<br><b>Anna Mika 6707 Gary Avenue</b>   |   |   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARDIORESPIRATORY ARREST</b><br><b>1850</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>CANCER OF PROSTATE WITH METASTASIS - YEARS</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>TO THE LUNG + BONE</b> |  |  |  |   |   |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br><b>MINUTES</b>   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)  |  |  |  |   |   |   |   |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |   |   |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |   |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>AUGUST 19 73</b> to <b>FEB 1, 19 82</b> , that (I) (we) last saw the deceased alive on <b>FEB 1 19 82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.    |  |  |  |   |   |   |   |
| 22b. SIGNATURE<br><b>B.C. Veneracion Jr</b>   |  |  |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>        |   | 22c. DATE SIGNED<br><b>2/1/82</b>   |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>B.C. VENERACION JR</b>  |  |  |  | 22e. ADDRESS<br><b>3401 Dundalk Ave 21222</b>   |   |   |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>2/4/82</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>St Stanislaus</b>  |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Maryland</b>                         |   |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Walter Dabrowski</b>   |  |  |  | ADDRESS<br><b>1005 Dundalk Avenue</b>   |   | 25a. DATE REC'D. BY REGISTRAR<br><b>FEB 5 1982</b>  |   |
|   |  |  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Thane J. [Signature]</b>   |   |   |   |

MEDICAL CERTIFICATION





NOT FOR CIRCULATION

U.S. DEPARTMENT OF JUSTICE

RECEIVED MAY 10 1964

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 must be retained by the hospital or attending physician.

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FOR  
1. STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |   |                                      |  |  |
|--|--|--|--|---|--------------------------------------|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>Julianna Miklewski</b>  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>2/7/82</b> |   | 2b. HOUR<br><b>1:04a<sub>M</sub></b> |  |  |
| 3. SEX<br><b>female</b>  |  | 4. RACE<br><b>white</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>4/24/11</b>  |                                      | 6. AGE (IN YEARS LAST BIRTHDAY)<br>YRS. MONTHS DAYS HOURS MIN.<br><b>70</b>  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>POLAND</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                      | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Balto City</b> MD.  |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>105 N. MILTON AVE.</b> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>housewife</b>  |                                      | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>MD</b>  |  |  |  | 13b. COUNTY<br><b>BALTO.</b>  |                                      | 13c. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>IGNATIUS</b>  |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>VALERIE</b>   |                                      |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, IF NOT UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>NO</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>217-56-6376A</b>  |  | 17. INFORMANT<br>ADDRESS<br><b>EDWARD MIKLEWSKI 105 N. MILTON AVE</b>   |                                      |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Lung ca., rt. squamous cell with metastasis to pleura and bone.</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) _____<br>DUE TO, OR AS A CONSEQUENCE OF (c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last |  |  |  |   |                                      |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____  |  |  |  |   |                                      |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |                                      | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |                                      |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |                                      |  |  |
| 22a. I certify that (1) (this hospital) attended the deceased from <b>1/1/82</b> , 19____, to <b>1/9/82</b> , 19____, that (1) (we) last saw the deceased alive on <b>1/9/82</b> , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) (I) did not view the body after death.)   |  |  |  |   |                                      |  |  |
| 22b. SIGNATURE<br><b>C. S. Chen</b> M.D.   |  |  |  | DEGREE<br><b>M.D.</b>   |                                      | 22c. DATE SIGNED<br><b>2/8/82</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>C. S. Chen, M.D.</b>   |  |  |  | 22e. ADDRESS<br><b>100 N. Broadway Balto., MD 21231</b>   |                                      |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>  |  | 23b. DATE<br><b>2-10-82</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>ST. STANISLAUS</b>   |                                      | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>BALTO</b>   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>JOHN M. WEBER &amp; SONS</b>  |  |  |  | 25a. DATE REC'D. BY REGISTRAR AND REGISTRAR'S SIGNATURE<br><b>FEB 9 1982</b>  |                                      |  |  |

BP

DDMH-16 50M 1/B1  
(VRA 15, 4)

Blank lined paper with two punch holes on the right side. Faint, illegible markings are visible across the page, including a circular stamp in the lower center and some handwritten scribbles.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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|  |  |   |                          |   |  |   |                            |  |
|--|--|---|--------------------------|---|--|---|----------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  | FIRST<br><b>ANTHONY</b>   | MIDDLE<br><b>VINCENT</b> | LAST<br><b>MILAUSKAS</b>  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>2 16 82</b> |   | 2b. HOUR<br><b>11:05AM</b> |  |
| 3. SEX<br><b>Male</b>  |  | 4. RACE<br><b>White</b>   |                          | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>6 13 19</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>62</b>  |                            | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |                          | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.                               |                            |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>University Hospital</b> |                          |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Taylor</b>               |                            | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Levo Brother</b>   |
| 13a. STATE<br><b>Maryland</b>  |  |   |                          | 13b. COUNTY   | 13c. CITY OR TOWN<br><b>Baltimore</b>              | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                            |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>Vincent Milauskas</b>  |  |   |                          | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Adella Paremiski</b>   |  |   |                            |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>YES</b>   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>WW II</b>   |                          | 17. INFORMANT ADDRESS<br><b>Joseph W. Miller 2901 New York Avenue 21227</b>   |  |   |                            |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>severe metabolic acidosis</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>acute renal failure</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>acute leukemia</b>   |  |   |                          |   |  |   |                            | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>12 hrs</b><br><b>3-4 days</b><br><b>? 2 months</b>                      |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)<br><b>urate nephropathy (probable)</b>  |  |   |                          |   |  |   |                            |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |                          |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       |                            | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. <b>19</b>   |                          | 21c. HOW INJURY OCCURRED<br>(ENTER NATURE OF INJURY IN ITEM 18: PART I OR PART 2)   |  |   |                            |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |                          | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |                            |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>2/15</b> 19 <b>82</b> to <b>2/16</b> 19 <b>82</b> , that (I) (we) lost<br>saw the deceased alive on <b>2/16</b> 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |  |   |                          |   |  |   |                            |  |
| 22b. SIGNATURE<br><b>Joan M. Bathon mo</b>   |  |   |                          | DEGREE  |  | 22c. DATE SIGNED<br><b>2/16/82</b>  |                            | 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Joan M. Bathon mo</b>  |
| 22e. ADDRESS<br><b>University Hospital</b>   |  |   |                          |   |  |   |                            |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>2/20/82</b>   |                          | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Most Holy Redeemer</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Maryland</b>                         |                            |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Hubbard Funeral Home, Inc.</b>  |  |   |                          | ADDRESS<br><b>4107 Wilkens Ave. 21229</b>   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>FEB 19 1982</b>   |                            |  |
|  |  |   |                          | 25b. REGISTRAR'S SIGNATURE<br><b>Frances Joan Bathon</b>  |  |   |                            |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in the office 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be called at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 4 0 2 2

1. FOR  
STATE  
REGISTRAR

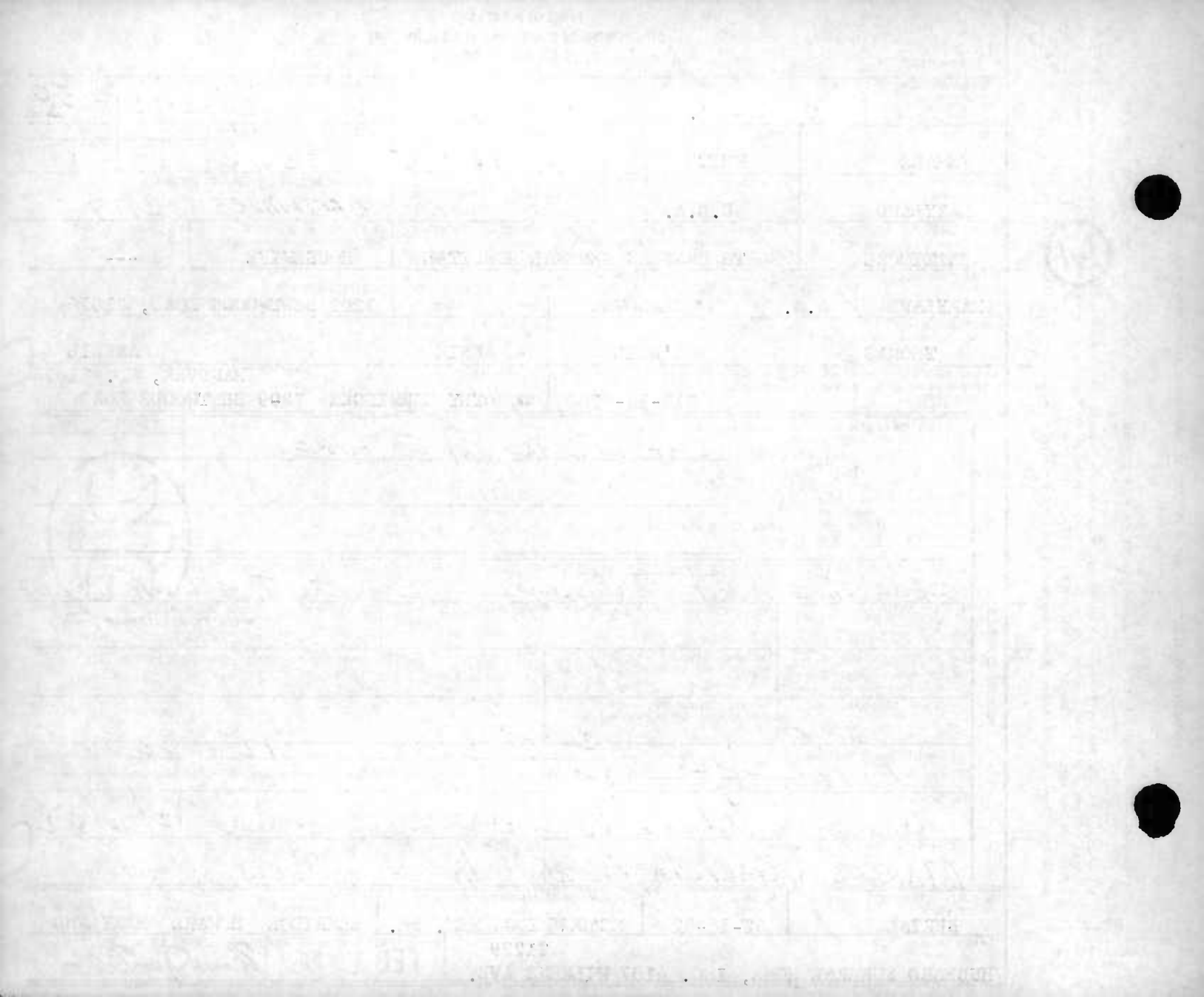
REG. NO.

|   |  |  |  |   |                                     |  |   |   |  |
|---|--|--|--|---|-------------------------------------|--|---|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>DOROTHY C. MILLER</b>                   |  |  | 2a. DATE OF DEATH<br>MONTH <b>2</b> DAY <b>12</b> YEAR <b>82</b>                         |   |                                     | 2b. HOUR<br><b>3:50</b> AM   |   |   |  |
| 3. SEX<br><b>FEMALE</b>   |  | 4. RACE<br><b>WHITE</b>  |  | 5. DATE OF BIRTH<br>MONTH <b>02</b> DAY <b>18</b> YEAR <b>25</b>  |                                     | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>56</b>   |   | 7. UNDER 1 YEAR<br>MONTHS <b>05</b> DAYS <b>15</b> HOURS <b>00</b> MIN. <b>00</b> |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MARYLAND</b>                      |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                     | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.                    |   |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>                                     |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>NORTH CHARLES GENERAL HOSPITAL</b> |  |   |                                     | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>HOUSEWIFE</b> |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>---</b>                                   |  |
| 13a. STATE<br><b>MARYLAND</b>   |  |  | 13b. COUNTY<br><b>A.A.</b>   |   | 13c. CITY OR TOWN<br><b>HANOVER</b> |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |  |
| 14. FATHER'S NAME<br>FIRST <b>THOMAS</b> MIDDLE <b>O'NEIL</b> LAST <b>MARKELL</b> |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>ANNIE</b> MIDDLE <b>MARKELL</b> LAST <b>MARKELL</b> |   |                                     | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>NO</b>       |   |   |  |
| 16b. SOCIAL SECURITY NO.<br><b>218-18-5200</b>                                    |  |  | 17. INFORMANT<br><b>DOROTHY HERRINGER</b>  |   |                                     | ADDRESS <b>HANOVER, MD. 21076</b>  |   |   |  |
| 17a. STREET ADDRESS<br><b>7209 BENTWOODS ROAD, 21076</b>                          |  |  | 17b. STREET ADDRESS<br><b>7209 BENTWOODS ROAD</b>  |   |                                     | 17c. STREET ADDRESS<br><b>7209 BENTWOODS ROAD</b>                                    |   |   |  |

|   |  |   |  |
|---|--|---|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CHRONIC RENAL FAILURE</b> |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |  |
| 5850<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which<br>gave rise to immediate<br>cause (a), stating the<br>underlying cause lost.             |  | (b) _____                                       |  |
| DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____   |  |   |  |

|  |  |   |  |
|--|--|---|--|
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>CONGESTIVE HEART FAILURE; CHRONIC OBSTRUCTIVE LUNG DISEASE</b>   |  |   |  |
| 19a. DATE OF OPERATION<br><b>2/12/82</b>   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>CHRONIC OBSTRUCTIVE LUNG DISEASE</b>                                   |  |
| 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  | 21d. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |
| 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |
| 21g. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21h. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>2/15/82</b> to <b>2/12/82</b> , that (I) (we) lost<br>saw the deceased alive on <b>2/12/82</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above. (I) (we) (did) (did not) view the body after death. |  |   |  |
| 22b. SIGNATURE<br><b>MARCOS B. GALICIA, Jr., MD</b>  |  | 22c. DATE SIGNED<br><b>2/12/82</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>MARCOS B. GALICIA, Jr., MD</b>   |  | 22e. ADDRESS<br><b>NORTH CHARLES GEN. Hosp.</b>   |  |

|   |  |                                     |  |   |  |   |  |
|---|--|-------------------------------------|--|---|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>     |  | 23b. DATE<br><b>02-15-82</b>        |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>MEADOWRIDGE MEM. PK.</b> |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>ELKRIDGE HOWARD MARYLAND</b> |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>HUBBARD FUNERAL HOME, INC.</b> |  | ADDRESS<br><b>4107 WILKENS AVE.</b> |  | 25a. DATE REC'D. BY REGISTRAR<br><b>FEB 16 1982</b>               |  | 25b. REGISTRAR'S SIGNATURE<br><b>James J. [Signature]</b>                     |  |





TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  |  |  |   |   |   |  |                              |
|---|--|---|--|--|--|---|---|---|--|------------------------------|
| FOR STATE REGISTRAR   |  |   |  |  | REG. NO.   |   |   |   |  |                              |
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>GEORGE M. MILLER</b>  |  |   |  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>FEB 26 '82</b>              |   |   |   |  | 2b. HOUR<br><b>6 30 P.M.</b> |
| 3. SEX<br><b>Male</b>   |  | 4. RACE<br><b>White</b>   |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>Nov. 10 1912</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>69</b> YRS.                                 |   | 7. IF UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 74 HRS. HOURS MIN.   |  |                              |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Md.</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>      |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.                 |   |   |  |                              |
| 11. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN BALTIMORE CITY, GIVE STREET ADDRESS)<br><b>UNION MEMORIAL HOSPITAL</b> |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Janitor</b>   |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Balto City</b>  |  |                              |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>Md.</b>   |  |   |  |  | 13b. COUNTY<br><b>-</b>  |   | 13c. CITY OR TOWN<br><b>Baltimore</b>                               |   | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                              |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>Frederick Miller</b>  |  |   |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Amelia Raulin</b> |   |   |   |  |                              |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>no</b>  |  |   |  |  | 16b. SOCIAL SECURITY NO.<br><b>213-03-5808</b>                     |   | 17. INFORMANT ADDRESS<br><b>Margaret Acor (sister) same address</b> |   |  |                              |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARDIO PULMONARY ARREST</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>SEPSIS AND RENAL FAILURE</b><br>DUE TO, OR AS A CONSEQUENCE OF (c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                             |  |   |  |  |  |   |   |   |  |                              |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a):<br><b>SMALL BOWEL OBSTRUCTION; PULMONARY EMBOLI</b>   |  |   |  |  |  |   |   |   |  |                              |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |                              |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |   |   |   |  |                              |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |   |   |   |  |                              |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>DEC. 3, 1981</b> to <b>FEB. 26, 1982</b> , that (I) (we) lost<br>saw the deceased alive on <b>FEB. 26, 1982</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |  |   |  |  |  |   |   |   |  |                              |
| 22b. SIGNATURE<br><i>[Signature]</i>  |  |   |  | DEGREE<br><b>M.D.</b> ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  |   |   | 22c. DATE SIGNED<br><b>FEB. 26, 1982</b>  |  |                              |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>I. KELLY-DOKUBO M.D.</b>  |  |   |  | 22e. ADDRESS<br><b>UNION MEMORIAL HOSPITAL</b>   |  |   |   |   |  |                              |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>3/2/82</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>St. Matthews Cem.</b>   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>Balto. Md.</b>                      |   |   |  |                              |
| 24. FUNERAL DIRECTOR<br><b>Schimunek Funeral Home, Inc.</b><br><b>3331 Brehms Lane, Balto. Md. 21213</b>  |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>MAR 3 1982</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>                                  |   |   |  |                              |

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UNITED STATES DEPARTMENT OF THE ARMY  
OFFICE OF THE CHIEF OF ENGINEERS  
WASHINGTON, D. C.

REPORT OF THE CHIEF OF ENGINEERS

UNITED STATES DEPARTMENT OF THE ARMY

OFFICE OF THE CHIEF OF ENGINEERS

WASHINGTON, D. C.

UNITED STATES DEPARTMENT OF THE ARMY

OFFICE OF THE CHIEF OF ENGINEERS

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UNITED STATES DEPARTMENT OF THE ARMY

OFFICE OF THE CHIEF OF ENGINEERS

WASHINGTON, D. C.

UNITED STATES DEPARTMENT OF THE ARMY (1917-1918)

UNITED STATES DEPARTMENT OF THE ARMY

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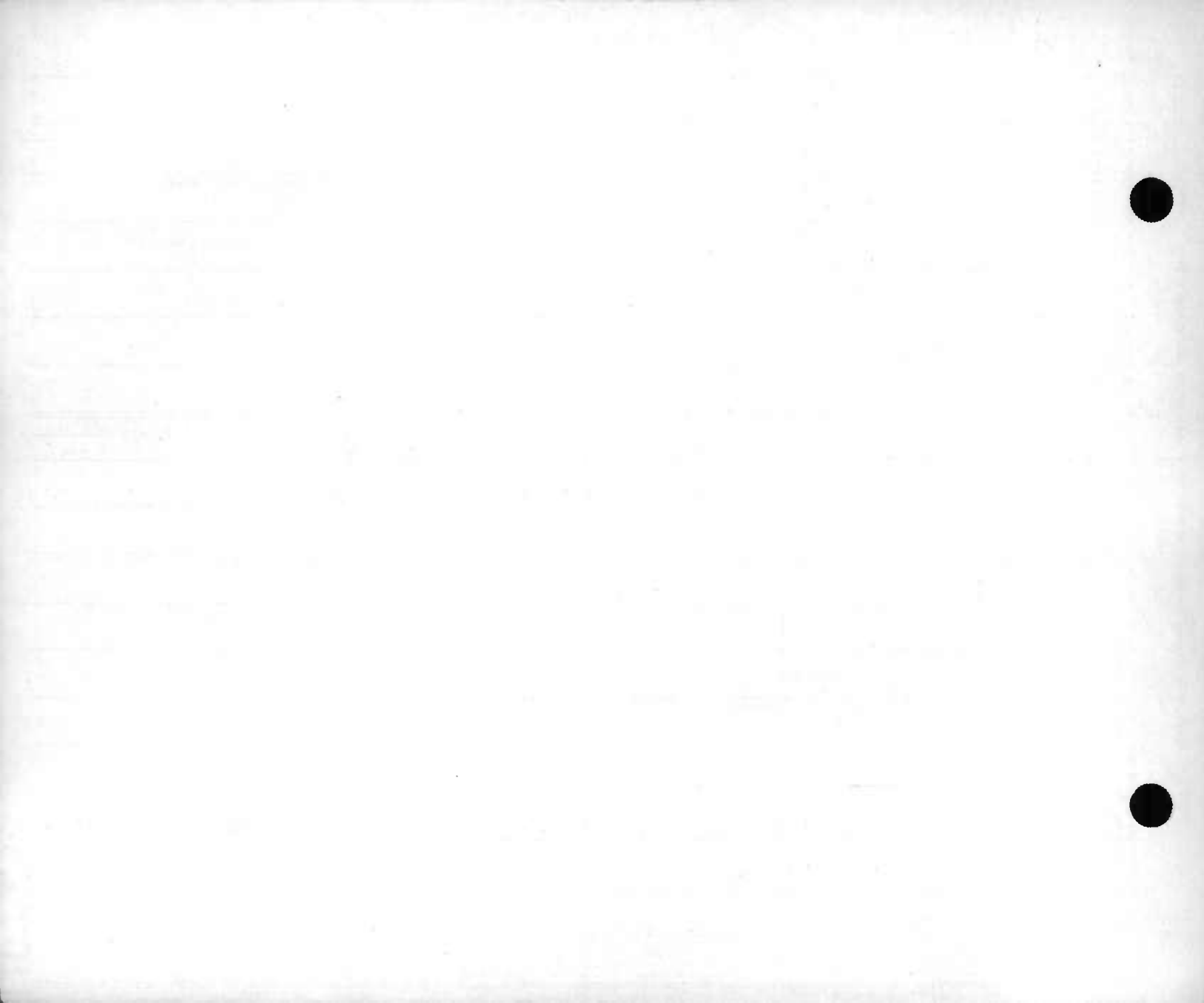
UNITED STATES DEPARTMENT OF THE ARMY

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |   |  |  |  |   |  |  |  |
|--|--|--|--|---|--|--|--|---|--|--|--|
| 1. FOR<br>STATE<br>REGISTRAR   |  | 2. REG. NO.  |  | 3. DECEASED NAME<br>(TYPE OR PRINT)   |  | 4. DATE OF DEATH   |  | 5. MONTH DAY YEAR   |  | 6. HOUR  |  |
| Hattie   |  | E.   |  | Miller  |  | February 4, 1982   |  |   |  | M  |  |
| 7. SEX   |  | 8. RACE  |  | 9. DATE OF BIRTH  |  | 10. AGE (IN YEARS LAST BIRTHDAY)                         |  | 11. IF UNDER 1 YEAR   |  | 12. IF UNDER 24 HRS                              |  |
| Female   |  | Black  |  | 9 MONTH 11 DAY 12 YEAR  |  | 69   |  | MONTHS DAYS   |  | HOURS MIN.                                       |  |
| 13. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 14. CITIZEN OF WHAT COUNTRY?   |  | 15. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 16. BALTIMORE CITY OR COUNTY OF DEATH                    |  |   |  |  |  |
| N.C.   |  | USA  |  |   |  | Baltimore City   |  |   |  | MD.  |  |
| 17. CITY OR TOWN OF DEATH  |  | 18. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 19. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 20. KIND OF BUSINESS OR INDUSTRY                         |  |   |  |  |  |
| Baltimore  |  | Union Memorial Hosp.   |  |   |  |  |  |   |  |  |  |
| 21. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  | 22. CITY OR TOWN   |  | 23. INSIDE CITY LIMITS?   |  | 24. STREET ADDRESS                                       |  |   |  |  |  |
| 13a. STATE   |  | 13b. COUNTY  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 2940 Harford Rd.   |  |   |  |  |  |
| MD   |  |  |  | Baltimore   |  |  |  |   |  |  |  |
| 25. FATHER'S NAME  |  | 26. MOTHER'S MAIDEN NAME   |  | 27. INFORMANT   |  | 28. ADDRESS  |  |   |  |  |  |
| FIRST MIDDLE LAST  |  | FIRST MIDDLE LAST  |  |   |  |  |  |   |  |  |  |
| Junious  |  | Edwards  |  | Lillie  |  | Pratt  |  |   |  |  |  |
| 29. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)   |  | 30. SOCIAL SECURITY NO.  |  | 31. ADDRESS   |  |  |  |   |  |  |  |
| No   |  | 238-20-6240  |  | Emma Flowers 283 Berkley Dr.  |  |  |  |   |  |  |  |
| 32. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |  |  |  |   |  |  |  |   |  | 33. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART I. DEATH WAS CAUSED BY:   |  |  |  |   |  |  |  |   |  | 30 min   |  |
| IMMEDIATE CAUSE (a) CARDIOPULMONARY ARREST   |  |  |  |   |  |  |  |   |  |  |  |
| 4960 DUE TO, OR AS A CONSEQUENCE OF  |  |  |  |   |  |  |  |   |  |  |  |
| (b) CHRONIC OBSTRUCTIVE PULMONARY DISEASE  |  |  |  |   |  |  |  |   |  | 30 years   |  |
| DUE TO, OR AS A CONSEQUENCE OF   |  |  |  |   |  |  |  |   |  |  |  |
| (c)  |  |  |  |   |  |  |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)  |  |  |  |   |  |  |  |   |  |  |  |
| OBESITY, HYPERTENSION  |  |  |  |   |  |  |  |   |  |  |  |
| 34. DATE OF OPERATION  |  | 35. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 36. AUTOPSY?   |  | 37. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |  |  |  |
|  |  |  |  |   |  | YES <input type="checkbox"/> NO <input type="checkbox"/> |  | YES <input type="checkbox"/> NO <input type="checkbox"/>      |  |  |  |
| 38. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 39. TIME OF INJURY   |  | 40. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)   |  |  |  |   |  |  |  |
|  |  | HOUR A.M. MONTH DAY YEAR   |  |   |  |  |  |   |  |  |  |
|  |  | P.M. 19  |  |   |  |  |  |   |  |  |  |
| 41. INJURY OCCURRED  |  | 42. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                     |  | 43. LOCATION  |  | CITY OR TOWN   |  | COUNTY  |  | STATE  |  |
| WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  |  |  | STREET  |  |  |  |   |  |  |  |
| 44. I certify that (1) (this hospital) attended the deceased from 19 82 to October 19 81, that (1) (we) lost saw the deceased alive on October 19 81, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did not) view the body after death. |  |  |  |   |  |  |  |   |  |  |  |
| 45. SIGNATURE  |  | DEGREE   |  |   |  | 46. DATE SIGNED  |  |   |  |  |  |
| W. G. McKenna  |  | M.D.   |  |   |  | Feb 4 1982   |  |   |  |  |  |
| 47. PHYSICIAN'S NAME (TYPE OR PRINT)   |  | 48. ADDRESS  |  |   |  |  |  |   |  |  |  |
| MCKENNA  |  | Johns Hopkins Hospital   |  |   |  |  |  |   |  |  |  |
| 49. BURIAL, CREMATION, REMOVAL (SPECIFY)   |  | 50. DATE   |  | 51. NAME OF CEMETERY OR CREMATORY   |  | 52. LOCATION   |  | CITY OR TOWN  |  | COUNTY STATE                                     |  |
| Burial   |  | 2/8/82   |  | Cedar Hill Cem.   |  | Baltimore  |  |   |  | Co. MD   |  |
| 53. FUNERAL DIRECTOR   |  |  |  | 54. DATE REC'D. BY REGISTRAR  |  |  |  | 55. REGISTRAR'S SIGNATURE                                     |  |  |  |
| NAME ADDRESS   |  |  |  | FEB 5 1982  |  |  |  | Name [Signature]  |  |  |  |
| Wm. C. March F/H 1101 E. North Ave.  |  |  |  |   |  |  |  |   |  |  |  |



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE MEDICAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGES 1, 2, AND 3 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED IN THE DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |  |  |  |  |  |  |  |   |  | REG. NO. 2 0 4 0 2 5  |  |
|--|--|--|--|--|--|--|--|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>JAMES R. MILLER</b>   |  |  |  |  |  | 2a. DATE KNOWN OF DEATH<br>ESTI. <input checked="" type="checkbox"/> MONTH DAY YEAR <b>2-25-82</b>                 |  | 2b. HOUR <b>4:30</b>  |  | M   |  |
| 3. SEX <b>male</b>   |  | 4. RACE <b>white</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR <b>June 20 1954</b>   |  | 6. AGE (IN YEARS)<br>LAST BIRTHDAY YRS. <b>27</b>  |  | IF UNDER 1 YR. MONTHS DAYS HOURS MIN.   |  | 7c. DATE PRONOUNCED DEAD<br>MONTH DAY YEAR <b>2-25-82</b>               |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Baltimore, Md.</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. <b>BALTIMORE CITY</b> OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.   |  |   |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>University Hospital</b> |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Plumber helper</b>                             |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Plumbing</b>                                |  |   |  |
| 13a. STATE<br><b>Maryland</b>  |  | 13b. CITY OR TOWN<br><b>Baltimore</b>  |  | 13c. CITY OR TOWN<br><b>Middle River</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                    |  | 13e. STREET ADDRESS<br><b>867 Maple Crest Dr. 21220</b>                             |  |   |  |
| 14. FATHER'S NAME<br>FIRST LAST <b>Calvin Miler</b>  |  |  |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST LAST <b>Juanita Beall</b>  |  |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN) <b>Yes</b>   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE YEAR OR DATES) <b>1972</b>   |  | 17. INFORMANT<br><b>Juanita Miller, Mother</b>   |  | ADDRESS<br><b>Same</b>   |  |   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1 DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>8147 Cranio-cerebral trauma</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____  |  |  |  |  |  |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                            |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).  |  |  |  |  |  |  |  |   |  |   |  |
| 19a. DATE OF OPERATION   |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  |  |  | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |   |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |  |  |  | 21b. TIME OF INJURY<br>HOUR:MIN:SEC MONTH DAY YEAR<br><b>9:30 PM 2-19-82</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)<br><b>pedestrian struck by a car</b> |  |   |  |   |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>  |  |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)<br><b>highway</b>  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br><b>Rt. 40 &amp; Middle River Road</b>                         |  |   |  |   |  |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |  |  |  |  |  |  |  |   |  |   |  |
| ACTUAL SIGNATURE <b>Margarita A. Koroll</b>  |  |  |  | TITLE (SPECIFY)<br><b>M.D. Assistant</b>   |  |  |  | DATE SIGNED <b>2-26-82</b>  |  |   |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT) <b>Margarita A. Koroll, M.D.</b>  |  |  |  | ADDRESS <b>111 Penn Street</b>   |  |  |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br><b>Burial</b>   |  |  |  | 23b. DATE<br><b>3/1/82</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Gardens of Faith Cemetery</b>   |  |   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Co., Md.</b> |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Bruzdzinski Funeral Home PA 1407 Old Eastern</b>  |  |  |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>MAR 3 1982</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>James Van Natten</b>                               |  |   |  |

RECEIVED

DOWN



15

15

15

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

|  |  |  |   |  |  |   |  |  |   |  |  |  |  |  |  |  |  |   |  |  |               |  |  |   |  |   |  |
|--|--|--|---|--|--|---|--|--|---|--|--|--|--|--|--|--|--|---|--|--|---------------|--|--|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  |  | FIRST<br>KEVIN  |  |  | MIDDLE<br>L.  |  |  | LAST<br>MILLER  |  |  | 2a. DATE KNOWN OF DEATH<br>ESTIMATED   |  |  | <input checked="" type="checkbox"/> MONTH<br>2 |  |  | DAY<br>17   |  |  | YEAR<br>19 82 |  |  | 2b. HOUR<br>M                               |  |   |  |
| 3. SEX<br>male   |  |  | 4. RACE<br>negro  |  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>9 27 59   |  |  | 6. AGE (IN YEARS)<br>LAST BIRTHDAY YRS.<br>22   |  |  | IF UNDER 1 YR.<br>MONTHS DAYS HOURS MIN.   |  |  | IF UNDER 24 HRS.                               |  |  | 7c. DATE PRONOUNCED DEAD<br>MONTH DAY YEAR<br>2 18 19 82                            |  |  | 7d. HOUR<br>M |  |  |   |  |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MD  |  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City  |  |  | MD.  |  |  |  |  |  |   |  |  |               |  |  |   |  |   |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore   |  |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>University Hospital |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)   |  |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |  |  |  |  |  |  |  |   |  |  |               |  |  |   |  |   |  |
| 13a. STATE<br>MD   |  |  | 13b. COUNTY   |  |  | 13c. CITY OR TOWN<br>Baltimore  |  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  | 13e. STREET ADDRESS<br>717 W. Saratoga St.   |  |  |  |  |  |   |  |  |               |  |  |   |  |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>James Miller   |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Ruth Turnage   |  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br>No   |  |  | 16b. SOCIAL SECURITY NO.<br>N/A   |  |  | 17. INFORMANT<br>Ruth Miller   |  |  | ADDRESS<br>717 W. Saratoga St.                 |  |  |   |  |  |               |  |  |   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>9654 IMMEDIATE CAUSE (a) Multiple gunshot wounds (unspecified weapon)<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last:<br>(b) DUE TO, OR AS A CONSEQUENCE OF<br>(c)  |  |  |   |  |  |   |  |  |   |  |  |  |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |  |               |  |  |   |  |   |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).  |  |  |   |  |  |   |  |  |   |  |  |  |  |  |  |  |  |   |  |  |               |  |  |   |  |   |  |
| 19a. DATE OF OPERATION   |  |  |   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  |  |   |  |  |  |  |  |  |  |  | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |               |  |  |   |  |   |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |  |  |   |  |  | 21b. TIME OF INJURY<br>HOUR <del>XX</del> MONTH DAY YEAR<br>11:40M. 2-17- 19 82   |  |  |   |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)<br>Subject was shot. |  |  |  |  |  |   |  |  |               |  |  |   |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK   |  |  |   |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)<br>bldg.  |  |  |   |  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br>742 W. Fayette St., Balto. Md.                |  |  |  |  |  |   |  |  |               |  |  |   |  |   |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> . |  |  |   |  |  |   |  |  |   |  |  |  |  |  |  |  |  |   |  |  |               |  |  |   |  |   |  |
| ACTUAL SIGNATURE<br><i>Ann M. Dixon</i>  |  |  |   |  |  |   |  |  |   |  |  | TITLE (SPECIFY)<br>M.D. Assistant MEDICAL EXAMINER   |  |  |  |  |  |   |  |  |               |  |  | DATE SIGNED<br>2-18-82                      |  |   |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)<br>Ann M. Dixon, M.D.   |  |  |   |  |  |   |  |  |   |  |  | ADDRESS<br>111 Penn St.  |  |  |  |  |  |   |  |  |               |  |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial   |  |  |   |  |  | 23b. DATE<br>2/22/82  |  |  |   |  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>King Memorial Pk.  |  |  |  |  |  | 23d. LOCATION<br>Baltimore Co. STA MD   |  |  |               |  |  |   |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Wm. C. March F/H   |  |  |   |  |  |   |  |  |   |  |  | ADDRESS<br>1101 E. North Ave.  |  |  |  |  |  |   |  |  |               |  |  | 25a. DATE REC'D BY REGISTRAR<br>FEB 22 1982 |  | 25b. REGISTRAR'S SIGNATURE<br><i>Thomas J. Martin</i> |  |



COTTON

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours of the death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at 1-800-368-1234.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 4 0 2 7

1- FOR  
STATE  
REGISTRAR

REG. NO.

|   |  |   |   |  |   |
|---|--|---|---|--|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>LOUISE A. MILLER  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>2 21 82  |  | 2b. HOUR<br>7:20 P.M.   |
| 3. SEX<br>Female  | 4. RACE<br>White   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>11 19 05  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>76 YRS.  |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br>Md  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.                                      |  |   |
| 10. CITY OR TOWN OF DEATH<br>Baltimore  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Good Samaritan Hospital |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Hair Dresser                |  | 12b. KIND OF BUSINESS OR INDUSTRY   |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>Md  | 13b. COUNTY<br>BALTO   | 13c. CITY OR TOWN<br>BALTO  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS<br>3206 Clearview Ave.<br>5601 Loch Raven Blvd.                  |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>George ----- MYERS  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>MINNIE ----- Schmidt   |   |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br>No   |  | 16b. SOCIAL SECURITY NO.<br>217-03-7853   |   | 17. INFORMANT<br>ADDRESS<br>Mr. George Miller, 5014 Pilgrim Rd. Balto. Md.           |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Cardiorespiratory arrest<br>1539<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) massive aspiration of stomach contents<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) intestinal obstruction          |  |   |   |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (d)<br>Carcinoma of colon (erected)  |  |   |   |  |   |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                  |  |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |
| 22a. I certify that (I) (this hospital) attended the deceased from FEBRUARY 8, 19 82, to FEB 21, 19 82, that (I) (we) last saw the deceased alive on 2-21 19 82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |   |  |   |
| 22b. SIGNATURE<br>Antonio S. Cassanego  |  | DEGREE<br>MD  |   | 22c. DATE SIGNED<br>2-21-82  |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Antonio S. Cassanego   |  | 22e. ADDRESS<br>5601 LOCH RAVEN BLVD.   |   |  |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial  | 23b. DATE<br>Feb. 24, 1982   | 23c. NAME OF CEMETERY OR CREMATORY<br>Cedar Hill Cemetery   | 23d. LOCATION<br>City or Town County State<br>Baltimore, Maryland                               |  |   |
| 24. FUNERAL DIRECTOR<br>NAME<br>McCutty Funeral Home, 130 E. Fort Ave, Balto. Md.   |  | 25a. DATE REC'D. BY REGISTRAR<br>FEB 24 1982  |   | 25b. REGISTRAR'S SIGNATURE<br>Dorcas Jean Wathen                                     |   |



ALL INFORMATION CONTAINED HEREIN IS UNCLASSIFIED

DATE 10-15-2010 BY SP-6 [illegible]

REASON: [illegible]

DATE 10-15-2010 BY SP-6 [illegible]

REASON: [illegible]

DATE 10-15-2010 BY SP-6 [illegible]

REASON: [illegible]

DATE 10-15-2010 BY SP-6 [illegible]

REASON: [illegible]

DATE 10-15-2010 BY SP-6 [illegible]

REASON: [illegible]

DATE 10-15-2010 BY SP-6 [illegible]

REASON: [illegible]

DATE 10-15-2010 BY SP-6 [illegible]

REASON: [illegible]

DATE 10-15-2010 BY SP-6 [illegible]

REASON: [illegible]

DATE 10-15-2010 BY SP-6 [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

1- FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 4 0 2 8

REG. NO.

|   |  |   |   |
|---|--|---|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>MILDRED S. Miller</b>  |  | 2a. DATE OF DEATH<br>MONTH <b>2</b> DAY <b>3</b> YEAR <b>82</b> HOUR <b>5:15</b> P.M.   |   |
| 3. SEX<br><b>Female</b>   | 4. RACE<br><b>White</b>  | 5. DATE OF BIRTH<br>MONTH <b>01</b> DAY <b>21</b> YEAR <b>47</b>  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>35</b> YRS.   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>NY New York</b>   | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA U.S.</b>  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.   |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Univ. of Md Hospital</b> | 12a. USUAL OCCUPATION<br>(TYPE OF WORK)<br><b>School Teacher</b>  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Education</b>   |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13b. STATE <b>Md Md.</b> 13c. CITY OR TOWN <b>Columbia</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |   |
| 14. FATHER'S NAME<br>FIRST <b>Julian</b> MIDDLE <b>N</b> LAST <b>McDermott</b>  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>Mildred</b> MIDDLE <b>Eisen</b> LAST <b>Eisen</b>  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(IF YES, GIVE WAR OR DATES)<br><b>No</b>  | 16b. SOCIAL SECURITY NO.<br><b>080-36-3258</b>   | 17. INFORMANT<br>ADDRESS<br><b>Randolph A. Miller same as # 13</b>  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiac Arrest</b><br><b>7476</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(b) <b>Due to, or as a consequence of Intracerebral hematoma -</b><br>(c) <b>Due to, or as a consequence of Arteriovenous Malformation</b> |  |   |   |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |   |   |
| 19a. DATE OF OPERATION<br><b>01/23/82</b>   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>Cerebral hematoma</b>   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)  |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/><br>AT HOME <input type="checkbox"/>   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   | 21f. LOCATION<br>STREET   | CITY OR TOWN COUNTY STATE   |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>01/21</b> , 19 <b>82</b> , to <b>02/03</b> , 19 <b>82</b> , that (I) (we) last saw the deceased alive on <b>02/03</b> , 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |   |   |
| 22b. SIGNATURE<br><b>E. Botero</b>  |  | 22c. DATE SIGNED<br><b>02/03/82</b>   |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>E. Botero</b>   |  | 22e. ADDRESS<br><b>Univ. of Maryland Hospital</b>   |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   | 23b. DATE<br><b>2/8/82</b>   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Meadowridge Memorial Pk.</b>   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Dorsey Md.</b>   |
| 24. FUNERAL DIRECTOR<br>NAME <b>Witzke P.A.</b><br>ADDRESS<br><b>5555 Twin Knolls Road, Columbia, Md. 21045</b>   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>FEB 9 1982</b>  |   |
|   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Frances Jean Nathan</b>  |   |

SECTION 1. The purpose of this document is to provide instructions to the Commissioner of the General Land Office regarding the management of the public lands.

SECTION 2. The Commissioner shall be responsible for the management of the public lands in accordance with the laws and regulations of the United States.

SECTION 3. The Commissioner shall be responsible for the management of the public lands in accordance with the laws and regulations of the United States.

SECTION 4. The Commissioner shall be responsible for the management of the public lands in accordance with the laws and regulations of the United States.

SECTION 5. The Commissioner shall be responsible for the management of the public lands in accordance with the laws and regulations of the United States.

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SECTION 10. The Commissioner shall be responsible for the management of the public lands in accordance with the laws and regulations of the United States.

SECTION 11. The Commissioner shall be responsible for the management of the public lands in accordance with the laws and regulations of the United States.

SECTION 12. The Commissioner shall be responsible for the management of the public lands in accordance with the laws and regulations of the United States.

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SECTION 14. The Commissioner shall be responsible for the management of the public lands in accordance with the laws and regulations of the United States.

SECTION 15. The Commissioner shall be responsible for the management of the public lands in accordance with the laws and regulations of the United States.

SECTION 16. The Commissioner shall be responsible for the management of the public lands in accordance with the laws and regulations of the United States.

SECTION 17. The Commissioner shall be responsible for the management of the public lands in accordance with the laws and regulations of the United States.

SECTION 18. The Commissioner shall be responsible for the management of the public lands in accordance with the laws and regulations of the United States.

SECTION 19. The Commissioner shall be responsible for the management of the public lands in accordance with the laws and regulations of the United States.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |  |  |   |  |                     |  | 8 2 0 4 0 2 9      |     |       |          |  |  |
|--|--|--|--|--|--|---|--|---------------------|--|--------------------|-----|-------|----------|--|--|
| 1. FOR STATE REGISTRAR   |  | REG. NO.   |  |  |  |   |  |                     |  |                    |     |       |          |  |  |
| 1. DECEASED NAME (TYPE OR PRINT)   |  | FIRST  |  | MIDDLE   |  | LAST  |  | 2a. DATE OF DEATH   |  | MONTH              | DAY | YEAR  | 2b. HOUR | A  |  |
| Robert   |  | G.   |  | Milligan   |  |   |  | 2/28/82             |  |                    |     |       | 9:30     | M  |  |
| 3. SEX   |  | 4. RACE  |  | 5. DATE OF BIRTH   |  | 6. AGE (IN YEARS LAST BIRTHDAY)                                     |  | 7. IF UNDER 1 YEAR  |  | 8. IF UNDER 24 HRS |     |       |          |  |  |
| Male   |  | Black  |  | 2 18 04  |  | 78  |  | MONTHS              |  | DAYS               |     | HOURS |          | MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>   |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |  |                     |  |                    |     |       |          |  |  |
| MD   |  | USA  |  |  |  | Baltimore City  |  |                     |  |                    |     |       |          | MD.  |  |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS OR INDUSTRY                                   |  |                     |  |                    |     |       |          |  |  |
| Baltimore  |  | Belair Convalesarium   |  |  |  |   |  |                     |  |                    |     |       |          |  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  | 13b. COUNTY  |  | 13c. CITY OR TOWN  |  | 13d. INSIDE CITY LIMITS?  |  | 13e. STREET ADDRESS |  |                    |     |       |          |  |  |
| MD   |  |  |  | Baltimore  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 725 George St.      |  |                    |     |       |          |  |  |
| 14. FATHER'S NAME  |  | 15. MOTHER'S MAIDEN NAME   |  |  |  |   |  |                     |  |                    |     |       |          |  |  |
| FIRST  |  | MIDDLE   |  | LAST   |  | FIRST   |  | MIDDLE              |  | LAST               |     |       |          |  |  |
| Arthur   |  |  |  | Milligan   |  | Mammie  |  |                     |  |                    |     |       |          |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)  |  | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT  |  | ADDRESS   |  |                     |  |                    |     |       |          |  |  |
| No   |  | 216-32-8684  |  | Edith Milligan   |  | 725 George St.  |  |                     |  |                    |     |       |          |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>RESPIRATORY FAILURE</u>  |  |  |  |  |  |   |  |                     |  |                    |     |       |          | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| 4292 } DUE TO, OR AS A CONSEQUENCE OF <u>CHRONIC C.H.F.</u>  |  |  |  |  |  |   |  |                     |  |                    |     |       |          |  |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO, OR AS A CONSEQUENCE OF <u>ASCVD</u>   |  |  |  |  |  |   |  |                     |  |                    |     |       |          |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>OLD CVA</u>   |  |  |  |  |  |   |  |                     |  |                    |     |       |          |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?      |  |                     |  |                    |     |       |          |  |  |
|  |  |  |  | YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | YES <input type="checkbox"/> NO <input type="checkbox"/>            |  |                     |  |                    |     |       |          |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)   |  |   |  |                     |  |                    |     |       |          |  |  |
|  |  | HOUR A.M. MONTH DAY YEAR   |  |  |  |   |  |                     |  |                    |     |       |          |  |  |
|  |  | P.M. 19  |  |  |  |   |  |                     |  |                    |     |       |          |  |  |
| 21d. INJURY OCCURRED   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  | 21f. LOCATION  |  |   |  |                     |  |                    |     |       |          |  |  |
| WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  |  |  | STREET   |  | CITY OR TOWN  |  | COUNTY              |  | STATE              |     |       |          |  |  |
|  |  |  |  |  |  |   |  |                     |  |                    |     |       |          |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>7/19</u> , 19 <u>79</u> , to <u>2/28</u> , 19 <u>82</u> , that (I) (we) last saw the deceased alive on <u>2/28</u> , 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |   |  |                     |  |                    |     |       |          |  |  |
| 22b. SIGNATURE   |  | DEGREE   |  | 22c. DATE SIGNED   |  |   |  |                     |  |                    |     |       |          |  |  |
|  |  |  |  | ATTENDING <input checked="" type="checkbox"/> MEDICAL <input checked="" type="checkbox"/> STAFF <input type="checkbox"/> PHYSICIAN <input type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/> |  | 3/1/82  |  |                     |  |                    |     |       |          |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  | 22e. ADDRESS   |  |  |  |   |  |                     |  |                    |     |       |          |  |  |
| Luis E. Rivera, M.D.   |  | 50 Scott Adam Road   |  |  |  |   |  |                     |  |                    |     |       |          |  |  |
|  |  | Cockeysville, Maryland 21030   |  |  |  |   |  |                     |  |                    |     |       |          |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION   |  |                     |  |                    |     |       |          |  |  |
| Burial   |  | 3/4/82   |  | Mt. Zion Cemetery  |  | Baltimore   |  | CITY OR TOWN        |  | COUNTY             |     | STATE |          |  |  |
|  |  |  |  |  |  |   |  |                     |  |                    |     |       |          |  |  |
| 24. FUNERAL DIRECTOR   |  | 25a. DATE REC'D. BY REGISTRAR  |  | 25b. REGISTRAR'S SIGNATURE   |  |   |  |                     |  |                    |     |       |          |  |  |
| NAME   |  | MAR 3 1982   |  | Charles Van Natta  |  |   |  |                     |  |                    |     |       |          |  |  |
| Wm. C. March F/H   |  | 1101 E. North Ave.   |  |  |  |   |  |                     |  |                    |     |       |          |  |  |

1 05:0 2/28/82 William Robert

Baltimore City

Baltimore Police Commissioner

2/28/82 2:28 PM

30 North Main Road  
Cockeysville, Maryland 21030

WE 2 24 17



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified before burial or cremation.

DHMH - 16 50M / 1B1  
(VRA 15, 4)

FOR  
1. STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 4 0 3 0

REG. NO.

|  |  |  |  |   |   |  |   |  |  |  |
|--|--|--|--|---|---|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>THOMAS C. MILLS   |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>2 9 82                          |   |   | 2b. HOUR<br>1:30 P.M.  |   |  |  |  |
| 3. SEX<br>MALE   |  | 4. RACE<br>BLACK   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>12 22 18  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>63 YRS.   |   | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>S.C.  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.   |   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Baltimore City Hospital |  |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)   |   | 12b. KIND OF BUSINESS OR INDUSTRY  |  |  |
| 13a. STATE<br>MD   |  |  | 13b. COUNTY  |   | 13c. CITY OR TOWN<br>Baltimore  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br>2919 Winchester St. |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>John Mills   |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Lucy Mills            |   |   |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>Yes  |  |  | 16b. SOCIAL SECURITY NO.<br>251-03-7046                                |   | 17. INFORMANT ADDRESS<br>Harriett Mills 2919 Winchester St.                       |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <u>CARDIOVASCULAR ARREST</u><br><u>1850</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>UREMIA</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>METASTATIC PROSTATIC CARCINOMA</u><br>Condiions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |  |  |   |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a   |  |  |  |   |   |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |   | 21c. HOW INJURY OCCURRED<br>(ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                 |  |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>2/1/82</u> to <u>2/9/82</u> , that (I) (we) last saw the deceased alive on <u>2/9/82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |  |  |   |   |  |   |  |  |  |
| 22b. SIGNATURE<br>Conrad May   |  |  | DEGREE   |   |   | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |   | 22c. DATE SIGNED<br>2/9/82   |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>CONRAD MAY  |  |  | 22e. ADDRESS<br>BALTIMORE CITY HOSPITAL                                |   |   |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial   |  |  | 23b. DATE<br>2/16/82   |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Md. Veteran Cem.                            |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Crownsville MD                                    |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Wm. C. March F/H 1101 E. North Ave.  |  |  |  |   | 25a. DATE REC'D. BY REGISTRAR<br>FEB 11 1982                                      |  | 25b. REGISTRAR'S SIGNATURE<br>Thomas J. Martin  |  |  |  |

MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH-16 30M 2/80  
(VRA 15, 4)1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 4 0 3 1

REG. NO.

|  |   |   |  |  |  |
|--|---|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>FRANK MISEK</b>  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>2 12 82</b>   |  | 2b. HOUR<br><b>7:20 PM</b>   |  |
| 3. SEX<br><b>M</b>   | 4. RACE<br><b>W</b>   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>11 20 55</b>   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>86</b> YRS.                              | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>—</b>  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>CITY-BALTIMORE</b> MD               |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>LUTHERAN HOSPITAL</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>—</b>   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>—</b>  |  |
| 13a. STATE<br><b>MARYLAND</b>  |   | 13b. COUNTY<br><b>—</b>   | 13c. CITY OR TOWN<br><b>BALTIMORE</b>  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   | 13e. STREET ADDRESS<br><b>3330 WILKENS AVE.</b>  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Wenceslaus Misesk</b>   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Antoinette Rungi</b>  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>No</b>  |   | 16b. SOCIAL SECURITY NO.<br><b>216-05-4957</b>  | 17. INFORMANT ADDRESS<br><b>Joyce S. Shores 11304 Charlund Dr. Kingsville</b>  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARDIO PULMONARY ARREST</b><br><b>4860</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>PNEUMONIA</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>—</b> |   |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)   |   |   |  |  |  |
| 19a. DATE OF OPERATION   |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>FEB 1</b> , 19 <b>82</b> , to <b>FEB 12</b> , 19 <b>82</b> , that (I) (we) last saw the deceased alive on <b>FEB 12</b> , 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                      |   |   |  |  |  |
| 22b. SIGNATURE<br><b>John H. Weber MD</b>  |   | DEGREE  |  | 22c. DATE SIGNED<br><b>2-12-82</b>   |  |
| 22b. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>JOHN H. WEBER MD</b>   |   | 22e. ADDRESS<br><b>LUTHERAN HOSPITAL</b>  |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  | 23b. DATE<br><b>2/15/82</b>   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Moreland Cem.</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore, Md.</b>  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Schimunek Funeral Home, Inc.</b>  |   | 25a. DATE REC'D. BY REGISTRAR<br><b>FEB 16 1982</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Francis J. Nathan</b>   |  |

MEDICAL CERTIFICATION

BP



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 4 0 3 2

FOR  
STATE  
REGISTRAR

REG. NO.

|   |   |  |  |  |  |
|---|---|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Chester Clarence Mitchell</b>  |   |  | 2a. DATE OF DEATH MONTH <b>2</b> / DAY <b>5</b> / YEAR <b>82</b>   |  | 2b. HOUR <b>11:35 PM</b>                     |
| 3. SEX<br><b>M</b>  | 4. RACE<br><b>White</b>   | 5. DATE OF BIRTH<br>MONTH <b>12</b> / DAY <b>28</b> / YEAR <b>26</b>   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>55</b> YRS   | 7. IF UNDER 1 YEAR<br>MONTHS <b>0</b> / DAYS <b>0</b> / HOURS <b>0</b> / MIN. <b>0</b> |  |
| 8. BIRTHPLACE<br>COUNTRY <b>Pa.</b>   | 9. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  | 10. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 11. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Balto. City</b> MD.  |  |  |
| 12. CITY OR TOWN OF DEATH<br><b>Balto. City</b>   | 13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>South Balto. Gen. Hosp.</b> | 14. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>truck driver</b>   | 15. KIND OF BUSINESS OR INDUSTRY<br><b>Materials Co.</b>   |  |  |
| 16. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE <b>Pa.</b> 13b. COUNTY <b>IN</b>  | 13c. CITY OR TOWN<br><b>Sellersville</b>  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   | 13e. STREET ADDRESS<br><b>2101 Old Bethlehem Pike</b>  |  |  |
| 14. FATHER'S NAME<br>FIRST <b>Edward</b> MIDDLE <b>-</b> LAST <b>Mitchell</b>   | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>Anna</b> MIDDLE <b>-</b> LAST <b>Blumenthal</b>  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>YES</b>   | 16b. SOCIAL SECURITY NO.<br><b>163-20-7232</b>  | 17. INFORMANT<br><b>Theresa H. Mitchell (same as 13e)</b>  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardioresp. arrest</b><br><b>1991</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>Metastatic Adenocarcinoma</b><br>(c) <b>DUE TO, OR AS A CONSEQUENCE OF</b> |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>-</b>   |   |  |  |  |  |
| 19a. DATE OF OPERATION<br><b>-</b>  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>-</b>  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)<br><b>-</b>   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br><b>-</b>  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>Jan. 28, 1982</b> to <b>Feb. 5, 1982</b> , that (I) (we) last saw the deceased alive on <b>Feb. 5, 1982</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                    |   |  |  |  |  |
| 22b. SIGNATURE<br><b>Janice I. Masi</b>   | DEGREE<br><b>M.D.</b>   | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                   | 22c. DATE SIGNED<br><b>2/5/82</b>  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Janice I. Masi</b>  | 22e. ADDRESS<br><b>3001 S. Hanover St. Balto Md 21238</b>   |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br><b>Burial</b>  | 23b. DATE<br><b>2/8/82</b>  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Rocky Ridge Mennonite</b>   | 23d. LOCATION<br><b>Quakertown</b>   | CITY STATE<br><b>Pa.</b>   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>George J. Gonce F.H. 4001 Ritchie Hwy.</b>   |   | 25a. DATE REC'D. BY REGISTRAR<br><b>FEB 9 1982</b>   |  | 25b. REGISTRAR<br><b>Charles J. Nathan</b>   |  |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 2 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified immediately.

*[Faint, mostly illegible handwritten text on lined paper. The text appears to be a letter or a series of notes, with some words like "Dear" and "I" visible.]*

George F. Jones F.R. Wood License No. 1000  
FEB 9 1935  
J. Jones

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |   |  |   |   |
|---|--|---|--|---|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Frederick<br/>HERBERT F. Mitchell</b>   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>2 15 82</b>                           |  | 2b. HOUR<br><b>7:28 PM</b>  |   |
| 3. SEX<br><b>Male</b>   |  | 4. RACE<br><b>Cauc.</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>1 19 1919</b>  |   |
| 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>63</b>  |  | 7. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                    |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   |
| 9. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Penna.</b>   |  | 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>                                   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Sinai Hospital</b>                          |   |
| 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Teacher</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Education</b>                           |  | 13. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.  |   |
| 13a. STATE<br><b>Md.</b>  |  | 13b. COUNTY<br><b>----</b>  |  | 13c. CITY OR TOWN<br><b>Balto.</b>  |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Frederick --- Mitchell</b>   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Mary --- Wilson</b>         |  | 16. SOCIAL SECURITY NO.<br><b>711-07-8004</b>   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>Yes</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>WW II</b>  |  | 17. INFORMANT<br>ADDRESS<br><b>Gloria H. Mitchell, 111 Hamlet Hill Road</b>   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY.<br>IMMEDIATE CAUSE (a) <b>4100 Acute MI</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>Cardiogenic Shock</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>Cardiogenic Shock</b>  |  |   |  |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |   |  |   |   |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. <b>19</b>               |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)          |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost<br>saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |  |   |  |   |   |
| 22b. SIGNATURE<br><b>D. S. Patel</b>  |  | DEGREE<br><b>MD</b>   |  | 22c. DATE SIGNED<br><b>2-15-82</b>  |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>D. S. PATEL, M.D.</b>   |  | 22e. ADDRESS<br><b>SINAI HOSPITAL</b>   |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                             |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Cremation</b>  |  | 23b. DATE<br><b>2/17/82</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Westview Mem. Pk</b>   |   |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore, Maryland</b>  |  | 24. FUNERAL DIRECTOR<br>NAME<br><b>Lemmon-Mitchell-Wiedefeld, 10 W. Padonia</b> |  | 25. DATE REC'D. BY REGISTRAR<br><b>FEB 18 1982</b>  |   |



THE UNIVERSITY OF CHICAGO  
LIBRARY

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. If a delay be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate is completed and filed by the attending physician, and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in the office with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the death certificate must be certified in green.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  |   |   |  |   |  |   |   |          |  |   |  |
|---|--|--|--|---|---|--|---|--|---|---|----------|--|---|--|
| FOR<br>1. STATE<br>REGISTRAR  |  |  |  |   | REG. NO.  |  |   |  |   |   |          |  |   |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Irene F. Mitchell  |  |  |  |   | 2a. DATE OF DEATH MONTH DAY YEAR<br>2-19-82                     |  |   |  |   | 2b. HOUR<br>12:16P  |          |  |   |  |
| 3. SEX<br>Female  |  | 4. RACE<br>Negro   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>Dec. 24-1907  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>74 YRS.                                   |   | IF UNDER 1 YEAR<br>MONTHS DAYS   |   | IF UNDER 24 HRS<br>HOURS MIN.   |          |  |   |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN<br>COUNTRY)<br>Va.  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.                   |   |  |   |   |          |  |   |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>John Hopkins Hospital |  |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Waitress |   |  | 12b. KIND OF BUSINESS OR<br>INDUSTRY<br>Dept. Store   |   |          |  |   |  |
| 13a. STATE<br>Md.   |  |  |  |   | 13b. COUNTY   |  | 13c. CITY OR TOWN<br>Baltimore                                |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   |          | 13e. STREET ADDRESS<br>1300 E. Lanvale St. |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Edward Nicholas   |  |  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Annie Lee West |  |   |  |   |   |          |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>NO  |  |  |  |   | 16b. SOCIAL SECURITY NO.<br>213-163478                          |  | 17. INFORMANT<br>ADDRESS<br>Mrs. Etta Owens 1745 Clifview Ave |  |   |   |          |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Myocardial Infarction<br>4100<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) Coronary Arteriosclerosis<br>20 years<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br>18 hours |  |  |  |   |   |  |   |  |   |   | 20 years |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I:<br>Gastrointestinal bleeding   |  |  |  |   |   |  |   |  |   |   |          |  |   |  |
| 19a. DATE OF OPERATION  |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   |  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |          |  |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   |  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)       |   |   |          |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   |  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |   |   |          |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from Feb 13/82 to Feb 19 1982, that (I) (we) lost<br>saw the deceased alive on Feb 19 1982, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above (I) (we) (did) (did not) view the body after death.                                  |  |  |  |   |   |  |   |  |   |   |          |  |   |  |
| 22b. SIGNATURE<br>S.B. Bolger MD  |  |  |  |   |   |  |   | DEGREE   |   | 22c. DATE SIGNED<br>Feb 19/82   |          |  |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Bolger   |  |  |  |   |   |  |   | 22e. ADDRESS<br>Johns Hopkins Hospital 600 N Wolfe St<br>Baltimore Md 21205          |   |   |          |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>Removal  |  |  |  | 23b. DATE<br>2-22-82  |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Garden of Rest Mxy                     |   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Dillwyn Buckingham Va.                            |   |          |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Randolph J. Collick   |  |  |  |   |   |  |   | ADDRESS<br>2431 E. Oliver St.  |   | 25a. DATE REC'D. BY REGISTRAR<br>FEB 23 1982  |          |  | 25b. REGISTRAR'S SIGNATURE<br>R. J. Collick |  |



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, DIRECTOR OF HEALTH SHALL EXECUTE THE CERTIFICATE. WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18, GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR RECORDS. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND. 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

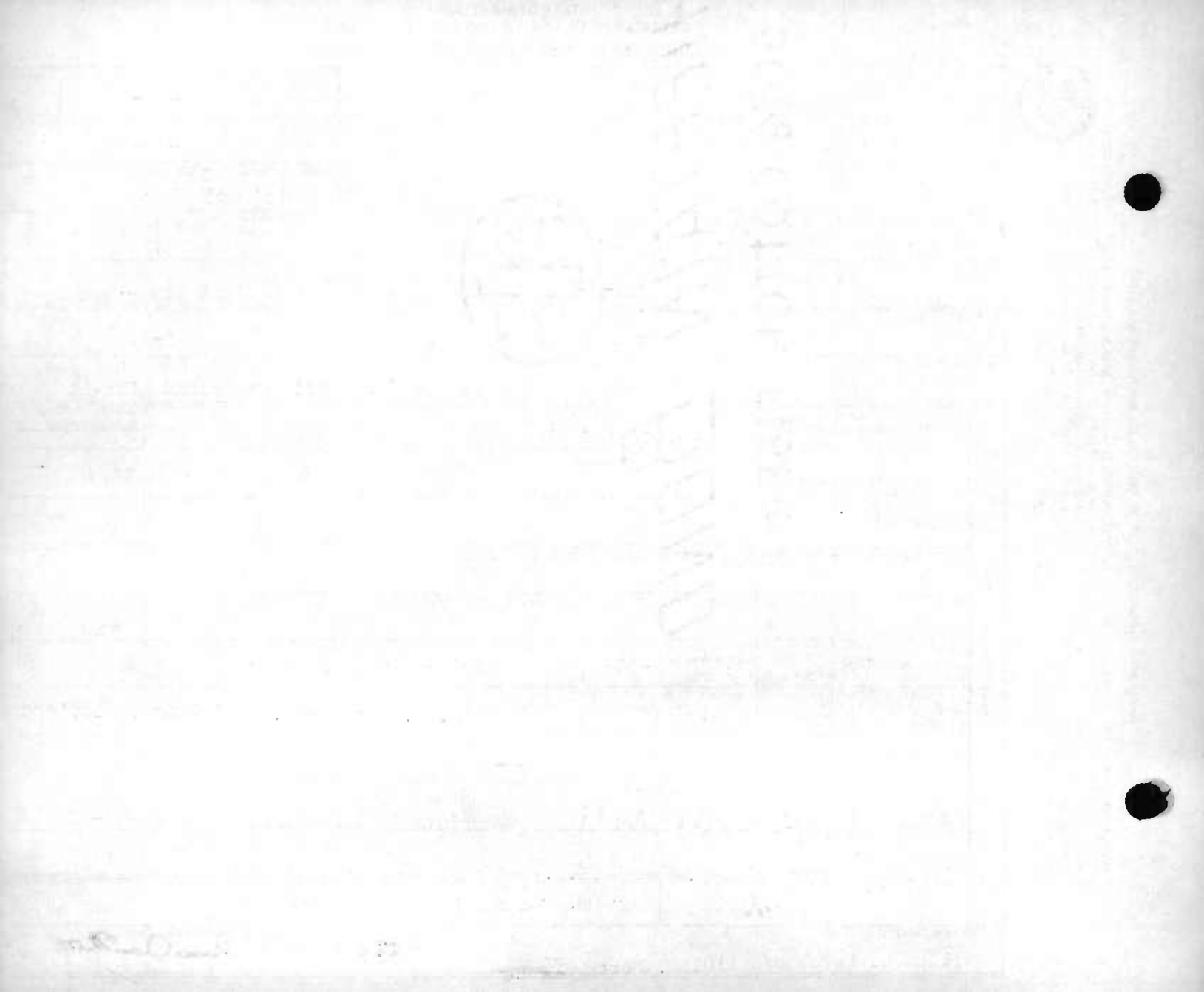
DHMH-17  
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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

|  |  |                              |  |  |  |                   |  |   |  |                  |  |   |  |  |  |                       |  |  |  |                                     |  |   |  |          |  |   |  |          |  |
|--|--|------------------------------|--|--|--|-------------------|--|---|--|------------------|--|---|--|--|--|-----------------------|--|--|--|-------------------------------------|--|---|--|----------|--|---|--|----------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  | FIRST                        |  | MIDDLE   |  | LAST              |  | 2a. DATE KNOWN OF DEATH   |  |                  |  | MONTH   |  |  |  | DAY                   |  |  |  | YEAR                                |  |   |  | 2b. HOUR |  |   |  |          |  |
| MARGARET   |  | B.                           |  |  |  | MITCHELL          |  | 2-11-82   |  |                  |  |   |  |  |  |                       |  |  |  |                                     |  | M |  |          |  |   |  |          |  |
| 3. SEX   |  | 4. RACE                      |  | 5. DATE OF BIRTH   |  | 6. AGE (IN YEARS) |  | IF UNDER 1 YR.  |  | IF UNDER 24 HRS. |  | 7c. DATE PRONOUNCED DEAD  |  |  |  | MONTH                 |  |  |  | DAY                                 |  |   |  | YEAR     |  |   |  | 2d. HOUR |  |
| female   |  | black                        |  | 11 25 07   |  | 74 YRS.           |  |   |  |                  |  | 2-11-82   |  |  |  |                       |  |  |  |                                     |  |   |  |          |  | M |  |          |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY? |  | 8. MARRIED   |  | NEVER MARRIED     |  | WIDOWED   |  | DIVORCED         |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |  |  |  |                       |  |  |  |                                     |  |   |  |          |  |   |  |          |  |
| Va   |  | USA                          |  |  |  |                   |  |   |  |                  |  | Baltimore City  |  |  |  |                       |  |  |  |                                     |  |   |  |          |  |   |  |          |  |
| 10. CITY OR TOWN OF DEATH  |  |                              |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |                   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                 |  |                  |  | 12b. KIND OF BUSINESS OR INDUSTRY                                   |  |  |  |                       |  |  |  |                                     |  |   |  |          |  |   |  |          |  |
| Baltimore  |  |                              |  | Provident Hospital   |  |                   |  |   |  |                  |  |   |  |  |  |                       |  |  |  |                                     |  |   |  |          |  |   |  |          |  |
| 13a. STATE   |  |                              |  | 13b. COUNTY  |  |                   |  | 13c. CITY OR TOWN   |  |                  |  | 13d. INSIDE CITY LIMITS?  |  |  |  | 13e. STREET ADDRESS   |  |  |  |                                     |  |   |  |          |  |   |  |          |  |
| md   |  |                              |  |  |  |                   |  | Baltimore   |  |                  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |  | 509 Cumberland Street |  |  |  |                                     |  |   |  |          |  |   |  |          |  |
| 14. FATHER'S NAME  |  |                              |  | 15. MOTHER'S MAIDEN NAME   |  |                   |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?                                  |  |                  |  | 16b. SOCIAL SECURITY NO.  |  |  |  | 17. INFORMANT         |  |  |  | ADDRESS                             |  |   |  |          |  |   |  |          |  |
| Sidney   |  |                              |  | Burrell Sr.  |  |                   |  | Pathenia  |  |                  |  | No  |  |  |  | N/A                   |  |  |  | Mary H. Jones 511 Cumberland Street |  |   |  |          |  |   |  |          |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Pelvic injuries<br>8147<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b)<br>(c)   |  |                              |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |                   |  |   |  |                  |  |   |  |  |  |                       |  |  |  |                                     |  |   |  |          |  |   |  |          |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).  |  |                              |  |  |  |                   |  |   |  |                  |  |   |  |  |  |                       |  |  |  |                                     |  |   |  |          |  |   |  |          |  |
| 19a. DATE OF OPERATION   |  |                              |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  |                   |  | 20. AUTOPSY?  |  |                  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |  |                       |  |  |  |                                     |  |   |  |          |  |   |  |          |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |  |                              |  | 21b. TIME OF INJURY  |  |                   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) |  |                  |  |   |  |  |  |                       |  |  |  |                                     |  |   |  |          |  |   |  |          |  |
|  |  |                              |  | 11:33PM 2-10-82  |  |                   |  | pedestrian struck by auto   |  |                  |  |   |  |  |  |                       |  |  |  |                                     |  |   |  |          |  |   |  |          |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>  |  |                              |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)  |  |                   |  | 21f. LOCATION   |  |                  |  | 2400blk. W. North Ave. Baltimore, Maryland                          |  |  |  |                       |  |  |  |                                     |  |   |  |          |  |   |  |          |  |
| 22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion |  |                              |  |  |  |                   |  |   |  |                  |  |   |  |  |  |                       |  |  |  |                                     |  |   |  |          |  |   |  |          |  |
| ACTUAL SIGNATURE   |  |                              |  | TITLE (SPECIFY)  |  |                   |  | DATE SIGNED   |  |                  |  |   |  |  |  |                       |  |  |  |                                     |  |   |  |          |  |   |  |          |  |
| Margarita A. Koroll, M.D.  |  |                              |  | M.D. Assistant   |  |                   |  | 2-11-82   |  |                  |  |   |  |  |  |                       |  |  |  |                                     |  |   |  |          |  |   |  |          |  |
| EXAMINER'S NAME (TYPE OR PRINT)  |  |                              |  | ADDRESS  |  |                   |  |   |  |                  |  |   |  |  |  |                       |  |  |  |                                     |  |   |  |          |  |   |  |          |  |
| Margarita A. Koroll, M.D.  |  |                              |  | 111 Penn Street  |  |                   |  |   |  |                  |  |   |  |  |  |                       |  |  |  |                                     |  |   |  |          |  |   |  |          |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  |                              |  | 23b. DATE  |  |                   |  | 23c. NAME OF CEMETERY OR CREMATORY  |  |                  |  | 23d. LOCATION   |  |  |  | COUNTY                |  |  |  | STATE                               |  |   |  |          |  |   |  |          |  |
| Burial   |  |                              |  | 2/16/82  |  |                   |  | Arbutus Memorial Park   |  |                  |  | Arbutus   |  |  |  | Md                    |  |  |  |                                     |  |   |  |          |  |   |  |          |  |
| 24. FUNERAL DIRECTOR   |  |                              |  | ADDRESS  |  |                   |  | 25a. DATE REC'D. BY REGISTRAR   |  |                  |  | 25b. REGISTRAR'S SIGNATURE  |  |  |  |                       |  |  |  |                                     |  |   |  |          |  |   |  |          |  |
| William C. March F/H   |  |                              |  | 1101 E. North Avenue   |  |                   |  | FEB 16 1982   |  |                  |  | Thomas J. Smith   |  |  |  |                       |  |  |  |                                     |  |   |  |          |  |   |  |          |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR  
1- STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 4 0 3 6

REG. NO.

|   |  |  |  |   |   |   |   |   |  |   |  |
|---|--|--|--|---|---|---|---|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>William J Moniodis</b>   |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>2-24-82</b>                  |   | 2b. HOUR<br><b>10<sup>45</sup> A<sup>M</sup></b>  |   |   |   |  |   |  |
| 3. SEX<br><b>Male</b>   |  | 4. RACE<br><b>White</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>7 19 28</b>  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>53</b><br>YRS. MONTHS DAYS HOURS MIN.                   |   |   |  |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Greece</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.                             |   |   |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>St. Agnes Hospital</b> |  |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Restaurateur</b> |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Food</b>                          |   |  |   |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>Md.</b>  |  |  |  | 13b. COUNTY<br><b>Baltimore</b>   |   | 13c. CITY OR TOWN<br><b>Baltimore</b>   |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>737 S. Tolna Street</b> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>James Moniodis</b>   |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Maria Zanos</b>   |   |   |   |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>Yes</b>  |  |  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE YEAR OR DATES)<br><b>WW 11 215-24-5316</b>  |   | 17. INFORMANT<br>ADDRESS<br><b>Evangelia Moniodis, 737 S. Tolna Street<br/>Baltimore, Md.</b> |   |   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>RESPIRATORY FAILURE</b><br><b>1629</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DO TO, OR AS A CONSEQUENCE OF (b) <b>STAGE IV Lung Carcinoma</b><br>DO TO, OR AS A CONSEQUENCE OF (c) |  |  |  |   |   |   |   |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH      |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)  |  |  |  |   |   |   |   |   |  |   |  |
| 19a. DATE OF OPERATION  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)                |   |   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>2/22</b> , 19 <b>82</b> , to <b>2/24</b> , 19 <b>82</b> , that (I) (we) last saw the deceased alive on <b>2/24</b> , 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                    |  |  |  |   |   |   |   |   |  |   |  |
| 22b. SIGNATURE<br><b>W. Bradley Pifalo</b>  |  |  |  |   |   | DEGREE<br><b>MD</b>   |   | 22c. DATE SIGNED<br><b>2/24/82</b>  |  |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>W. Bradley Pifalo</b>   |  |  |  |   |   | 22e. ADDRESS<br><b>St. Agnes Hospital</b>   |   |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |  |  | 23b. DATE<br><b>2-27-82</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Greek Orthodox Cem.</b>                        |   |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Baltimore Md.</b>                    |  |   |  |
| 24. FUNERAL DIRECTOR<br><b>Nicholas T. Matthews, 3021 Eastern Avenue<br/>Baltimore, Md.</b>   |  |  |  |   |   | 25a. DATE REC'D. BY REGISTRAR<br><b>MAR 1 1982</b>  |   | 25b. REGISTRAR'S SIGNATURE<br><b>Frances Jan Nathan</b>   |  |   |  |

10-11-12

10-11-12

10-11-12



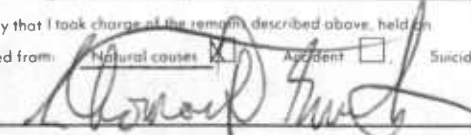

RECEIVED



10-11-12



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 IN YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED. WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH   |                      |   |   |  |   |   |   |  |  | REG. NO. 2 0 4 0 3 7 |  |
|---|----------------------|---|---|--|---|---|---|--|--|----------------------|--|
| 1. FOR STATE REGISTRAR  |                      |   |   |  |   |   |   |  |  |                      |  |
| 1. DECEASED NAME (TYPE OR PRINT) <b>John H. Monroe</b>  |                      |   |   |  |   | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> ESTIMATED <input type="checkbox"/> MONTH DAY YEAR <b>2 9 1982</b> |   | 2b. HOUR <b>M</b>  |  |                      |  |
| 3. SEX <b>Male</b>  | 4. RACE <b>Black</b> | 5. DATE OF BIRTH MONTH DAY YEAR <b>10 26 20</b>   | 6. AGE (IN YEARS LAST BIRTHDAY) <b>61</b> YRS.              | IF UNDER 1 YR. MONTHS DAYS   | IF UNDER 24 HRS. HOURS MIN.   | 2c. DATE PRONOUNCED DEAD MONTH DAY YEAR <b>2 9 1982</b>   |   | 2d. HOUR <b>7:20A</b> <b>M</b>   |  |                      |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>VA</b>   |                      | 7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>   |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City,</b> <b>MD.</b>  |   |  |  |                      |  |
| 10. CITY OR TOWN OF DEATH <b>Baltimore</b>  |                      | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>4675 Park Heights Avenue</b> |   |  |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)   |   | 12b. KIND OF BUSINESS OR INDUSTRY  |  |                      |  |
| 13a. STATE <b>MD</b>  |                      | 13b. COUNTY   |   | 13c. CITY OR TOWN <b>Baltimore</b>   |   | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                  |   | 13e. STREET ADDRESS <b>4675 Park Heights Ave.</b>                                |  |                      |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST <b>John H. Monroe Sr.</b>   |                      |   |   | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Mary Turner</b>  |   |   |   |  |  |                      |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>No</b>  |                      |   | 16b. SOCIAL SECURITY NO. <b>258-34-5150</b>                 |  | 17. INFORMANT ADDRESS <b>Mary Cox Hasty 4724 Wakefield Rd.</b>                |   |   |  |  |                      |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Arteriosclerotic cardiovascular disease</b><br><b>4292</b><br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b) _____<br>(c) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>DUE TO, OR AS A CONSEQUENCE OF  |                      |   |   |  |   |   |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |                      |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).   |                      |   |   |  |   |   |   |  |  |                      |  |
| 19a. DATE OF OPERATION  |                      |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?           |  |   |   |   | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |                      |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |                      |   | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b> |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) |   |   |  |  |                      |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK   |                      |   | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                |   |   |  |  |                      |  |
| 22a. I certify that I took charge of the remains described above. held on death resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion |                      |   |   |  |   |   |   |  |  |                      |  |
| ACTUAL SIGNATURE    |                      |   | TITLE (SPECIFY) <b>Deputy Chief</b> M.D.                    |  |   | MEDICAL EXAMINER  |   | DATE SIGNED <b>2/9/82</b>  |  |                      |  |
| EXAMINER'S NAME (TYPE OR PRINT) <b>Thomas D. Smith, M.D.</b>  |                      |   | ADDRESS <b>111 Penn St. Balto., MD.</b>                     |  |   |   |   |  |  |                      |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>   |                      | 23b. DATE <b>2/12/82</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY <b>King Memorial Pk.</b>  |   |   | 23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore Co. MD</b> |  |  |                      |  |
| 24. FUNERAL DIRECTOR NAME <b>Wm. C. March F/H</b> ADDRESS <b>1101 E. North Ave.</b>   |                      |   |   | 25a. DATE REC'D. BY REGISTRAR <b>FEB 10 1982</b>   |   | 25b. REGISTRAR'S SIGNATURE               |   |  |  |                      |  |

BP

13819 MOTION PICTURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  | 8 2 0 4 0 3 8   |  |  |  |
|--|--|---|--|---|--|--|--|
| 1. FOR STATE REGISTRAR   |  |   |  | REG. NO.  |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>OLIVIA B. MONTANA</b>   |  |   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>02-15-82</b>  |  | 2b. HOUR<br><b>7:00</b> M  |  |
| 3. SEX<br><b>FEMALE</b>  |  | 4. RACE<br><b>BLACK</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>07-21-09</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>72</b> YRS.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MD</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>North Charles General</b> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE <b>MD</b> 13b. COUNTY <b>Baltimore</b>  |  |   |  | 13c. CITY OR TOWN<br><b>Baltimore</b>   |  | 13d. INSIDE CITY LIMITS?<br><b>YES</b> <input checked="" type="checkbox"/> <b>NO</b> <input type="checkbox"/>                            |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Harry Brickhouse</b>  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Annie</b>   |  | 13e. STREET ADDRESS<br><b>6804 Townbrook Dr.</b>  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>N/A</b>  |  | 17. INFORMANT ADDRESS<br><b>Ruth Junious 6804 Townbrook Dr.</b>   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>MALORY-WEISS SYNDROME</b><br><b>5307</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>RENAL INSUFFICIENCY, CHRONIC</b>   |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br><b>YES</b> <input type="checkbox"/> <b>NO</b> <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br><b>YES</b> <input type="checkbox"/> <b>NO</b> <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>02-06</b> , 19 <b>82</b> , to <b>02-15</b> , 19 <b>82</b> , that (I) (we) lost<br>saw the deceased alive on <b>02-15</b> , 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.  |  |   |  |   |  |  |  |
| 22b. SIGNATURE<br><b>Cesar Gamboa</b> M.D. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>  |  |   |  | 22c. DATE SIGNED<br><b>02-15-82</b>   |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>CESAR GAMBOA, M.D.</b>   |  |   |  | 22e. ADDRESS<br><b>N-CHARLES HOSPITAL</b>   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>2/20/82</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>King Memorial Pk.</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore CO. MD</b>  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Wm. C. March F/H</b>  |  |   |  | 24b. ADDRESS<br><b>1101 E. North Ave.</b>   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>FEB 17 1982</b>  |  |
|  |  |   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Thomas J. [Signature]</b>  |  |  |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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(VRA 15, 4)

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  | 8 2 0 4 0 3 9  |  |  |  |
|--|--|--|--|--|--|--|--|
| 1. FOR STATE REGISTRAR   |  |  |  | REG. NO.   |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>ANN M. MOOG</b>   |  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR <b>2 21 82</b> 2b. HOUR <b>6:00 A.M.</b>  |  |  |  |
| 3. SEX <b>Female</b>   |  | 4. RACE <b>White</b>   |  | 5. DATE OF BIRTH MONTH DAY YEAR <b>2 11 96</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY) <b>85</b> YRS. MONTHS DAYS HOURS MIN.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>  |  | 7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.   |  |
| 10. CITY OR TOWN OF DEATH <b>Baltimore</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>South Baltimore General Hosp</b> |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housekeeper</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13a. STATE <b>Maryland</b>   |  | 13b. CITY OR TOWN <b>Glen Burnie</b>   |  | 13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 13e. STREET ADDRESS <b>6668 Roberts Ct. Apt. B78</b>   |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST <b>JOSEPH AKERS</b>  |  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>CLARIE HEPBING</b>   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b>  |  | 16b. SOCIAL SECURITY NO. <b>216-61-6810</b>  |  | 17. INFORMANT ADDRESS <b>Ethel Lupton 788 Nabbs Creek Rd.</b>  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>LIVER Cirrhosis</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>And bleeding esophageal varices</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>varices</b>   |  |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>5715</b>   |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION <b>-</b>  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>-</b>  |  | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. - 19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) <b>-</b>  |  |  |  |
| 21d. INJURY OCCURRED <b>-</b> WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) <b>-</b>   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>-</b>  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>JANUARY 29, 19 82</b> to <b>FEBRUARY 21, 19 82</b> , that (I) (we) last saw the deceased alive on <b>FEBRUARY 17, 19 82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |  |  |
| 22b. SIGNATURE <b>Herbert Juarez, M.D.</b> DEGREE  |  |  |  | 22c. DATE SIGNED <b>2/21/82</b>  |  | 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>HERBERT JUARBE</b>  |  |
| 22e. ADDRESS <b>South Baltimore General Hospital</b>   |  |  |  | 22f. ADDRESS   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>  |  | 23b. DATE <b>24 Feb. 82</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY <b>Balto. National Cem.</b>   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore Md.</b>   |  |
| 24. FUNERAL DIRECTOR <b>James S. Kirkley Glen Burnie</b>   |  |  |  | 25a. DATE REC'D. BY REGISTRAR <b>FEB 22 1982</b> 25b. REGISTRAR'S SIGNATURE <b>James S. Kirkley</b>  |  |  |  |

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White

Smith

Conseiller

6666 Robert St. Apt. 576

Alvin Smith

Maryland

Abel Linton 78 Webb Creek Rd.

no

Hotel 24 Feb. 88 Balto. National Con. Baltimore

James S. Hixley Glen Burnie

Feb 23 1888

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.350  
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## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  | REG. NO. 8204040   |  |  |  |
|--|--|---|--|--|--|--|--|
| 1. FOR STATE REGISTRAR   |  |   |  |  |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>JOHN R. MORDECAI</b>  |  |   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR <b>FEB. 5 1982</b>   |  | 2b. HOUR<br><b>9:30 PM</b>   |  |
| 3. SEX<br><b>MALE</b>  |  | 4. RACE<br><b>WHITE</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR <b>MAY 23 1907</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>74</b> YRS.  |  |
| 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Md.</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>      |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore</b> <b>City</b> MD.   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>N. Charles General Hospital</b> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Driver</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Trucks</b>   |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |   |  |  |  |  |  |
| 13a. STATE<br><b>Md.</b>   |  | 13b. COUNTY<br><b>Baltimore</b>   |  | 13c. CITY OR TOWN<br><b>Baltimore</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>George Mordecai</b>   |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Champ Robinson</b>   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>Yes</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>WWII</b>   |  | 17. INFORMANT ADDRESS<br><b>John M. Mordecai 220 Stony Run Ln.</b>   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>PNEUMONIA</b><br><b>4860</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |  |   |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>UTI</b>  |  |   |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>JAN. 8 19 82</b> , to <b>FEB. 5 19 82</b> , that (I) (we) last saw the deceased alive on <b>FEB. 5 19 82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                    |  |   |  |  |  |  |  |
| 22b. SIGNATURE<br><b>Emergencia Soares</b>   |  |   |  | DEGREE<br><b>M.D.</b> ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br><b>2-5-82</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>C. UERGARA - SOARES</b>  |  |   |  | 22e. ADDRESS<br><b>N. CHARLES GEN. HOSP. BALT. MD. 21218</b>   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Cremation</b>   |  | 23b. DATE<br><b>2/17/82</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Green Mount Cem.</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore, Md.</b>  |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>MITCHELL-WIEDEFELD HOME, INC. 6500 York Rd.</b>   |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>FEB 18 1982</b>  |  |  |  |
|  |  |   |  | 25b. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>   |  |  |  |





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 4 0 4 1

1. FOR  
STATE  
REGISTRAR

REG. NO.

|   |   |   |   |  |  |
|---|---|---|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>MADLIN M. Morehead  |   |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>2 26 82                                |  | 2b. HOUR<br>9 07 P.M.  |
| 3. SEX<br>Female  | 4. RACE<br>W  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>04 15 26  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>55 YRS.   | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Balt. Md   | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.                           |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Mercy Hospital |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Homemaker |  | 12b. KIND OF BUSINESS OR INDUSTRY                                |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>Md  |   |   | 13b. COUNTY<br>-  | 13c. CITY OR TOWN<br>Baltimore   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Charles H. Swayne   |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Madeline M. MARTIN           |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>NO  |   | 16b. SOCIAL SECURITY NO.<br>214-20 0607   |   | 17. INFORMANT<br>ADDRESS<br>Wm. T. MOREHEAD SR. SAME 21224                           |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Metastatic Breast Carcinoma<br>1749<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last |   |   |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                     |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a  |   |   |   |  |  |
| 19a. DATE OF OPERATION<br>-   |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br>-   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |   |   |   |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 2/12, 19 82 to 2/26, 19 82, that (I) (we) lost<br>saw the deceased alive on 2/26, 19 82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.   |   |   |   |  |  |
| 22b. SIGNATURE<br>Edward C. Watters III, M.D.   |   | DEGREE<br>M.D.  |   | 22c. DATE SIGNED<br>2/27/82  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Edward C. Watters III  |   | 22e. ADDRESS<br>Mercy Hospital  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(TYPE IF)<br>BURIAL  |   | 23b. DATE<br>3-3-82   |   | 23c. NAME OF CEMETERY OR CREMATORY<br>CEDAR HILL CEM.                                |  |
| 23d. LOCATION<br>CITY OR TOWN<br>A.A. CO. MD.   |   | 23e. DATE REC'D. BY REGISTRAR<br>MAR 1 1982   |   |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>HOFFMANN-SKARDA   |   | ADDRESS<br>3218 HUDSON ST.  |   | 25b. REGISTRAR'S SIGNATURE<br>Frances Jean Nathan                                    |  |



RECEIVED  
JAN 10 1964  
FEDERAL BUREAU OF INVESTIGATION  
U.S. DEPARTMENT OF JUSTICE

TO : DIRECTOR, FBI  
FROM : SAC, NEW YORK  
SUBJECT: [Illegible]  
[Illegible text follows, mostly obscured by bleed-through and faintness.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 4 0 4 2

REG. NO.

|  |  |   |  |   |                            |  |  |
|--|--|---|--|---|----------------------------|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Joseph Andrew Morgereth</b>   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR <b>2/28/82</b> |   | 2b. HOUR<br><b>8:30 AM</b> |  |  |
| 3. SEX<br><b>male</b>  |  | 4. RACE<br><b>white</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR <b>2 23 02</b>   |                            | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>80</b> YRS.  |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY) <b>Maryland</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                            | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>South Baltimore Gen</b> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Superintendent</b>   |                            | 12b. BUSINESS OR INDUSTRY<br><b>Southern States Coop.</b>  |  |
| 13a. STATE<br><b>md.</b>   |  | 13b. COUNTY<br><b>Baltimore</b>   |  | 13c. CITY OR TOWN<br><b>Baltimore</b>   |                            | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                            |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Joseph H. Morgereth</b>   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Ursula Schmidt</b>  |  | 13e. STREET ADDRESS<br><b>7308 Conley St.</b>   |                            |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>No</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>216-07-8952</b>  |  | 17. INFORMANT<br><b>Margaret C. Morgereth-Balto., MD. 21224</b>   |                            |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Heart failure</b><br><b>2030</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:<br>(b) <b>Multiple myeloma</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>DUE TO, OR AS A CONSEQUENCE OF |  |   |  |   |                            |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____   |  |   |  |   |                            |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                            | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |                            |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |                            |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>11-23-81</b> , 19 <b>81</b> , to <b>2-28</b> , 19 <b>82</b> , that (I) (we) last saw the deceased alive on <b>2/22</b> 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.                     |  |   |  |   |                            |  |  |
| 22b. SIGNATURE<br><b>B. Winston</b>  |  | DEGREE<br><b>MD</b>   |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>                  |                            | 22c. DATE SIGNED<br><b>2/28/82</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>B. Winston</b>   |  | 22e. ADDRESS<br><b>South Baltimore General Hosp.</b>  |  |   |                            |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>3/3/1982</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Most Holy Redeemer</b>   |                            | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Maryland</b>  |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Duda-Ruck, Inc.<br/>7922 Wise Avenue Dundalk, MD. 21222</b>   |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>MAR 3 1982</b>  |                            | 25b. REGISTRAR'S SIGNATURE<br><b>James J. Nathan</b>   |  |

Washington City

July 25

My dear Mr. [illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

Items #18a-22a Film G565 3/30/82 re STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

|  |         |  |  |   |  |  |  |                          |  |                                |  |        |  |        |  |      |  |             |  |
|--|---------|--|--|---|--|--|--|--------------------------|--|--------------------------------|--|--------|--|--------|--|------|--|-------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |         | FIRST  |  | MIDDLE  |  | LAST   |  | 2a. DATE OF DEATH        |  | KNOWN ESTI-<br>MATED           |  | MONTH  |  | DAY    |  | YEAR |  | 2b. HOUR    |  |
| GEORGE   |         | N.   |  |   |  | MORTON   |  | 2                        |  | 11                             |  | 19     |  | 82     |  |      |  | M           |  |
| 3. SEX   | 4. RACE | 5. DATE OF BIRTH   |  | 6. AGE (IN YEARS<br>LAST BIRTHDAY)  |  | IF UNDER 1 YR.   |  | IF UNDER 24 HRS.         |  | 7c. DATE<br>PRONOUNCED<br>DEAD |  | MONTH  |  | DAY    |  | YEAR |  | 2d. HOUR    |  |
| male   | negro   | 12 25 50   |  | 31 YRS.   |  |  |  |                          |  | 2                              |  | 11     |  | 19     |  | 82   |  | 4:22<br>P M |  |
| 7a. BIRTHPLACE (STATE OR<br>FOREIGN COUNTRY)   |         | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH   |  |                          |  |                                |  |        |  |        |  |      |  |             |  |
| BALTIMORE  |         | USA  |  |   |  | Baltimore City   |  |                          |  |                                |  |        |  |        |  |      |  | MD.         |  |
| 10. CITY OR TOWN OF DEATH  |         | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)                         |  | 12a. USUAL OCCUPATION (TYPE OF WORK<br>FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS<br>OR INDUSTRY   |  |                          |  |                                |  |        |  |        |  |      |  |             |  |
| Baltimore  |         | 1401 Madison Ave.  |  |   |  |  |  |                          |  |                                |  |        |  |        |  |      |  |             |  |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)                                     |         | 13a. STATE   |  | 13b. COUNTY   |  | 13c. CITY OR TOWN  |  | 13d. INSIDE CITY LIMITS? |  | 13e. STREET ADDRESS            |  |        |  |        |  |      |  |             |  |
| MD   |         | BALTIMORE  |  | BALTIMORE   |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 1622 W. SARATOGA ST.     |  |                                |  |        |  |        |  |      |  |             |  |
| 14. FATHER'S NAME  |         | FIRST  |  | MIDDLE  |  | LAST   |  | 15. MOTHER'S MAIDEN NAME |  | FIRST                          |  | MIDDLE |  | LAST   |  |      |  |             |  |
| GEORGE   |         |  |  |   |  | DIXON  |  | KATHELEEN                |  |                                |  |        |  | MORTON |  |      |  |             |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)  |         | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT   |  | ADDRESS  |  |                          |  |                                |  |        |  |        |  |      |  |             |  |
| NO   |         |  |  |   |  | KATHLEEN MORTON 5520 RELCREST RD. 21206  |  |                          |  |                                |  |        |  |        |  |      |  |             |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1 DEATH WAS CAUSED BY:                       |         | IMMEDIATE CAUSE (a)  |  | Intravenous narcotism   |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH  |  |                          |  |                                |  |        |  |        |  |      |  |             |  |
| 3049   |         |  |  |   |  |  |  |                          |  |                                |  |        |  |        |  |      |  |             |  |
| Conditions, if any, which<br>gave rise to immediate<br>cause (a) stating the under-<br>lying cause last.                       |         | (b)  |  | DUE TO, OR AS A CONSEQUENCE OF  |  |  |  |                          |  |                                |  |        |  |        |  |      |  |             |  |
|  |         | (c)  |  | DUE TO, OR AS A CONSEQUENCE OF  |  |  |  |                          |  |                                |  |        |  |        |  |      |  |             |  |
|  |         |  |  |   |  |  |  |                          |  |                                |  |        |  |        |  |      |  |             |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 |         |  |  |   |  |  |  |                          |  |                                |  |        |  |        |  |      |  |             |  |
| 19a. DATE OF OPERATION   |         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  | 20. AUTOPSY?  |  |  |  |                          |  |                                |  |        |  |        |  |      |  |             |  |
|  |         |  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |  |  |                          |  |                                |  |        |  |        |  |      |  |             |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR<br>CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH      |         | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |  |  |  |                          |  |                                |  |        |  |        |  |      |  |             |  |
|  |         |  |  |   |  |  |  |                          |  |                                |  |        |  |        |  |      |  |             |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE<br>AT WORK <input type="checkbox"/>                   |         | 21e. PLACE OF INJURY (AT HOME,<br>STREET, FACTORY, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |                          |  |                                |  |        |  |        |  |      |  |             |  |
|  |         |  |  |   |  |  |  |                          |  |                                |  |        |  |        |  |      |  |             |  |
| 22a. I certify that I took charge of the remains described above, held on  |         | Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion |  | death resulted from:  |  | Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |  |                          |  |                                |  |        |  |        |  |      |  |             |  |
| ACTUAL<br>SIGNATURE  |         | TITLE (SPECIFY)  |  | M.D. Assistant  |  | MEDICAL EXAMINER   |  | DATE<br>SIGNED           |  | 2-12-82                        |  |        |  |        |  |      |  |             |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)   |         | Ann M. Dixon, M.D.   |  | ADDRESS   |  | 111 Penn St.   |  |                          |  |                                |  |        |  |        |  |      |  |             |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)   |         | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE   |  |                          |  |                                |  |        |  |        |  |      |  |             |  |
| burial   |         | 2/17/82  |  | KING MEMORIAL PARK  |  | BALTIMORE CO., MD  |  |                          |  |                                |  |        |  |        |  |      |  |             |  |
| 24. FUNERAL DIRECTOR<br>NAME   |         | ADDRESS  |  | 25a. DATE REC'D. BY REGISTRAR   |  | 25b. REGISTRAR'S SIGNATURE   |  |                          |  |                                |  |        |  |        |  |      |  |             |  |
| WM.C. MARCH F/H 1101 E. NORTH AVENUE   |         |  |  | FEB 16 1982   |  | James J. Nathan  |  |                          |  |                                |  |        |  |        |  |      |  |             |  |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PM-3. RETAIN PAGE 1. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED IN THE DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH-17  
(VR A15 ME (5))  
15M 2/80

1901



RECEIVED

1912



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be retained by the funeral director within 2 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH-16 30M 2/80  
(VRA 15, 4)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 4 0 4 4

FOR  
STATE  
REGISTRAR

REG. NO.

|   |   |   |  |  |  |
|---|---|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>JAMES E. MORTON  |   |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>02 01 1982                |  | 2b. HOUR<br>M  |
| 3. SEX<br>MALE  | 4. RACE<br>NEGRO  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>03 05 1905  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>76 YRS.   | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>VIRGINIA   | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.   |  |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>NORTH CHASE GENERAL HOSPITAL |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE) |  | 12b. KIND OF BUSINESS OR INDUSTRY  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>STATE<br>Maryland   |   |   | 13b. COUNTY  | 13c. CITY OR TOWN<br>PARK  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>George Wilkins  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE<br>Ella King   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No  |   | 16b. SOCIAL SECURITY NO.<br>212-09-6144   |  | 17. INFORMANT<br>ADDRESS<br>Thelma Parham 665 W. Chester Ave.  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>UROSEPSIS</u><br><u>2500</u> DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>CHRONIC RENAL FAILURE</u><br>(c) <u>DM AND BWD</u> |   |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>hrs<br>months<br>yrs.  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)  |   |   |  |  |  |
| 19a. DATE OF OPERATION  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |
| 22a. I certify that (I) (the hospital) attended the deceased from <u>01 FEB</u> 19 <u>82</u> , to <u>01 FEB</u> 19 <u>82</u> , that (I) (we) lost saw the deceased alive on <u>01 FEB</u> 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death. |   |   |  |  |  |
| 22b. SIGNATURE<br><u>[Signature]</u>  |   | DEGREE  |  | 22c. DATE SIGNED<br><u>02/01/82</u>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>Dr. A.M. WEBSON</u>   |   | 22e. ADDRESS<br><u>7140 FORDS LANE 21245</u>  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial   |   | 23b. DATE<br>2/5/82   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>King Memorial Pk.  |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore Co. MD  |   | 23e. DATE REC'D. BY REGISTRAR<br>FEB 4 1982   |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Wm. C. March F/H  |   | 1101 E. North Ave.  |  | 25. REGISTRAR'S SIGNATURE<br><u>[Signature]</u>  |  |

MEDICAL CERTIFICATION

1

1



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 3 and 4 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 4 0 4 5

REG. NO.

|   |  |  |   |   |                                       |  |   |  |  |   |  |
|---|--|--|---|---|---------------------------------------|--|---|--|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>ALICE J. MOUTON</b>  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>FEB 6 82</b>                      |   |                                       | 2b. HOUR<br>M  |   |  |  |   |  |
| 3. SEX<br><b>FEMALE</b>   |  | 4. RACE<br><b>NEGRO</b>  |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>10 30 10</b>   |                                       | 6. AGE (IN YEARS LAST BIRTHDAY)<br>YRS<br><b>72</b>                                  |   | IF UNDER 1 YEAR<br>MONTHS DAYS<br><b>4</b> |  | IF UNDER 74 HRS<br>HOURS MIN.<br><b>4</b> |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>BALTIMORE MD</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                       | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.                    |   |  |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>SINAI HOSPITAL</b> |   |   |                                       | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>DOMESTIC</b>  |   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>at home</b>  |   |  |
| 13a. STATE<br><b>MD</b>   |  |  | 13b. COUNTY<br><b>BALTIMORE</b>   |   | 13c. CITY OR TOWN<br><b>BALTIMORE</b> |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>1761 KURNOW PL</b>   |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>WENNY JOHNSON</b>  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>ELIZABETH V. NELSON</b> |   |                                       |  |   |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>   |  |  | 16b. SOCIAL SECURITY NO.<br><b>2502</b>                                     |   |                                       | 17. INFORMANT<br>ADDRESS<br><b>WILLIAM C. CROFT 4022 WILSON RD</b>                   |   |  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiac arrest</b><br><b>2502</b><br>DUE TO, OR AS A CONSEQUENCE OF:<br>(b) <b>Non Ketotic Hyperosmolar Diabetic coma</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:<br>(c) <b>Dehydration, Renal Failure</b> |  |  |   |   |                                       |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>1 day</b><br><b>1 week</b><br><b>1 week</b>                             |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:<br><b>Atherosclerotic C.V. Disease - Thoracic atherosclerosis</b>  |  |  |   |   |                                       |  |   |  |  |   |  |
| 19a. DATE OF OPERATION  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                            |   |                                       | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                  |   |                                       | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |   |  |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)      |   |                                       | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |   |  |  |   |  |
| 22a. I certify that (I) (the hospital) attended the deceased from <b>Feb 2</b> , 19 <b>82</b> , to <b>Feb 6</b> , 19 <b>82</b> , that (I) (we) lost<br>saw the deceased alive on <b>Feb 6</b> , 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.                              |  |  |   |   |                                       |  |   |  |  |   |  |
| 22b. SIGNATURE<br><b>Manuel Levin MD</b><br>DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>  |  |  |   |   |                                       |  |   |  | 22c. DATE SIGNED<br><b>2/6/82</b>  |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>MANUEL LEVIN M.D.</b>   |  |  |   |   |                                       | 22e. ADDRESS<br><b>6101 PK HTS AVE BALTO MD 21215</b>                                |   |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>   |  |  | 23b. DATE<br><b>2/11/82</b>   |   |                                       | 23c. NAME OF CEMETERY OR CREMATORY<br><b>MT RUGMAN</b>                               |   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>BALTIMORE MD</b>  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Manfred A. Hargis</b><br>ADDRESS<br><b>635 S. 5th St</b>   |  |  |   |   |                                       | 25a. DATE RECEIVED BY REGISTRAR<br><b>FEB 8 1982</b>                                 |   |  |  |   |  |
| 25b. REGISTRAR'S SIGNATURE<br><b>Francis J. Nathan</b>  |  |  |   |   |                                       |  |   |  |  |   |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

1. FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 4 0 4 6

REG. NO.

|  |  |  |   |   |                     |  |                                      |  |
|--|--|--|---|---|---------------------|--|--------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>VADA PARR MOYER   |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>2/8/82                   |   | 2b. HOUR<br>3:10 PM |  |                                      |  |
| 3. SEX<br>FEMALE   |  | 4. RACE<br>WHITE   |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>02 05 08  |                     | 6. AGE (IN YEARS, MONTHS, DAYS)<br>75 YRS  |                                      |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>VIRGINIA  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                     | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.   |                                      |  |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>South Baltimore Gen |   | 12a. USUAL OCCUPATION (IF OF WORK FOR MOST OF WORKING LIFE)<br>FACTORY WORKER   |                     | 12b. KIND OF BUSINESS OR INDUSTRY<br>UNKNOWN   |                                      |  |
| 13a. STATE<br>MARYLAND   |  | 13b. CITY OR TOWN<br>BALTIMORE   |   | 13c. INSIDE CITY LIMITS?<br>NO <input checked="" type="checkbox"/>  |                     | 13d. STREET ADDRESS<br>165 POUTON STREET, 21227  |                                      |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>GEORGE SMITH   |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>ARTIE McDORMAN |   |                     |  |                                      |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>NO   |  | 16b. SOCIAL SECURITY NO.<br>218-16-1728  |   | 17. INFORMANT<br>MARY R. DEBUS  |                     |  | ADDRESS<br>2208 GAYLAWN DRIVE, 21227 |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Ventricular Fibrillation = CPT<br>4100<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) Heart Disease (Ventricular dysfunction)<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) S/P Acute Ant MI 1/2/82<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |  |   |   |                     |  |                                      |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)  |  |  |   |   |                     |  |                                      |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |                     | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                                      |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |                     |  |                                      |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |                     |  |                                      |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost<br>saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.  |  |  |   |   |                     |  |                                      |  |
| 22b. SIGNATURE<br>Stephen Calhoun MD   |  |  |   | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>        |                     | 22c. DATE SIGNED<br>2/9/82   |                                      |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Stephen Calhoun   |  |  |   | 22e. ADDRESS<br>South Baltimore Gen Hosp  |                     |  |                                      |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>BURIAL   |  | 23b. DATE<br>02-13-82  |   | 23c. NAME OF CEMETERY OR CREMATORY<br>MEADOWRIDGE MEM. PK.  |                     | 23d. LOCATION<br>CITY OR TOWN COUNTY<br>ELKCRIDGE HOWARD MARYLAND  |                                      |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>HUBBARD FUNERAL HOME, INC., 4107 WILKENS AVE.  |  |  |   | 24b. ADDRESS<br>21227   |                     | 25a. DATE REC'D. BY REGISTRAR<br>FEB 11 1982   |                                      |  |



2005-02

SBX 11837

1981

U.S. DEPARTMENT OF JUSTICE

19-05-01

1981

U.S. DEPARTMENT OF JUSTICE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 4 0 4 7

REG. NO.

|  |  |  |  |   |   |   |   |  |  |   |  |
|--|--|--|--|---|---|---|---|--|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>ADAM John MULBAUER SR   |  |  | 2b. DATE OF DEATH<br>MONTH DAY YEAR<br>2 4 82                          |   |   | 2c. HOUR<br>5529 PM   |   |  |  |   |  |
| 3. SEX<br>male   |  | 4. RACE<br>white   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>April 13, 1900  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>81 YRS.  |   | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.   |  |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.  |   |  |  |   |  |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>UNION MEMORIAL HOSPITAL |  |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Baltimore City Fire Department  |   | 12b. KIND OF BUSINESS OR INDUSTRY  |  |   |  |
| 13a. STATE<br>MARYLAND   |  |  | 13b. COUNTY<br>BALTIMORE   |   | 13c. CITY OR TOWN<br>CATONSVILLE  |   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS<br>6110-A Edmondson Ave. 21228 |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>John Muhlbauser  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Anna Neumann          |   |   | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>YES WWI   |   |  |  | 16b. SOCIAL SECURITY NO.<br>216-40-1762 |  |
| 17. INFORMANT<br>ADDRESS<br>A. John Mulbauer Jr., 2900 Ridge Rd., 21207  |  |  |  |   |   |   |   |  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Adenocarcinoma primary unknown<br>1991<br>DUE TO, OR AS A CONSEQUENCE OF (b) liver mets<br>DUE TO, OR AS A CONSEQUENCE OF (c) villous adenoma or adenocarcinoma cecum           |  |  |  |   |   |   |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH       |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)  |  |  |  |   |   |   |   |  |  |   |  |
| 19a. DATE OF OPERATION   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |   | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) |   |   |  |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                             |   |   |  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 1/20/82, 19, to 2/4/82, 19, that (I) (we) last saw the deceased alive on 2/3/82, 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |  |  |  |   |   |   |   |  |  |   |  |
| 22b. SIGNATURE<br>John H Apple   |  |  | DEGREE<br>MD   |   |   | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |   |  | 22c. DATE SIGNED                                   |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>John H Apple  |  |  | 22e. ADDRESS<br>UMH  |   |   |   |   |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial   |  |  | 23b. DATE<br>2/06/82   |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Glen Haven                              |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Glen Burnie, A. C. Md.                            |  |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME Loring Byers Funeral Directors Inc<br>ADDRESS 8728 Liberty Road, Randallstown, Md. 21133  |  |  |  |   |   | 25a. DATE REC'D. BY REGISTRAR<br>FEB 9 1982   |   | 25b. REGISTRAR'S SIGNATURE<br>James Van Natten   |  |   |  |





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law also requires that the death certificate be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrars, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  | REG. NO. 8 2 0 4 0 4 8  |  |
|---|--|---|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) <b>VIRGINIA MAY MULLALLY</b>   |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR 2-24-82  |  |
| 3. SEX <b>Female</b>  |  |   |  | 2b. HOUR 2:45 M   |  |
| 4. RACE <b>White</b>  |  | 5. DATE OF BIRTH MONTH DAY YEAR 3-1-25  |  | 6. AGE (IN YEARS, LAST BIRTHDAY) 56 YRS   |  |
| 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>  |  | 7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |
| 10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>ST. AGNES HOSPITAL</b>                              |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b> MD.  |  |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>SECRETARY</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY <b>UNION</b>  |  |   |  |
| 13a. STATE <b>MARYLAND</b>  |  | 13b. COUNTY <b>BALTIMORE</b>  |  | 13c. CITY OR TOWN <b>ARBUTUS</b>  |  |
| 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 13e. STREET ADDRESS <b>1308 ELM ROAD, 21227</b>   |  |   |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST <b>PAUL D. PETRY</b>  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>ADA MAY HURLEY</b>  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>   |  | 16b. SOCIAL SECURITY NO. <b>216-20-7317</b>   |  | 17. INFORMANT ADDRESS <b>JACK H. PETRY 1085 ELM ROAD, 21227</b>   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br><b>1629 Probable Septis.</b><br>IMMEDIATE CAUSE (a) <b>Probable Septis.</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>Metastatic Small Cell Ca Lung</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>congestive heart failure.</b>                        |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a   |  |   |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |   |  |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>2/1</b> , 19 <b>82</b> , to <b>2/24</b> , 19 <b>82</b> , that (I) (we) lost saw the deceased alive on <b>2/24</b> , 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |  |   |  |
| 22b. SIGNATURE <b>Bach T Duong</b>  |  | DEGREE <b>M.D.</b> ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED <b>2/24/82</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>BACH T DUONG</b>   |  | 22e. ADDRESS <b>ST AGNES HOSPITAL</b>   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>   |  | 23b. DATE <b>02-26-82</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY <b>LOUDON PARK</b>   |  |
| 23d. LOCATION CITY OR TOWN COUNTY STATE <b>BALTIMORE CITY MARYLAND</b>  |  |   |  |   |  |
| 24. FUNERAL DIRECTOR NAME <b>HUBBARD FUNERAL HOME, INC.</b>   |  | ADDRESS <b>4107 WILKENS AVE.</b>  |  | 25a. DATE REC'D. BY REGISTRAR <b>FEB 26 1982</b>  |  |
| 25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>   |  |   |  |   |  |

WATER

WATER

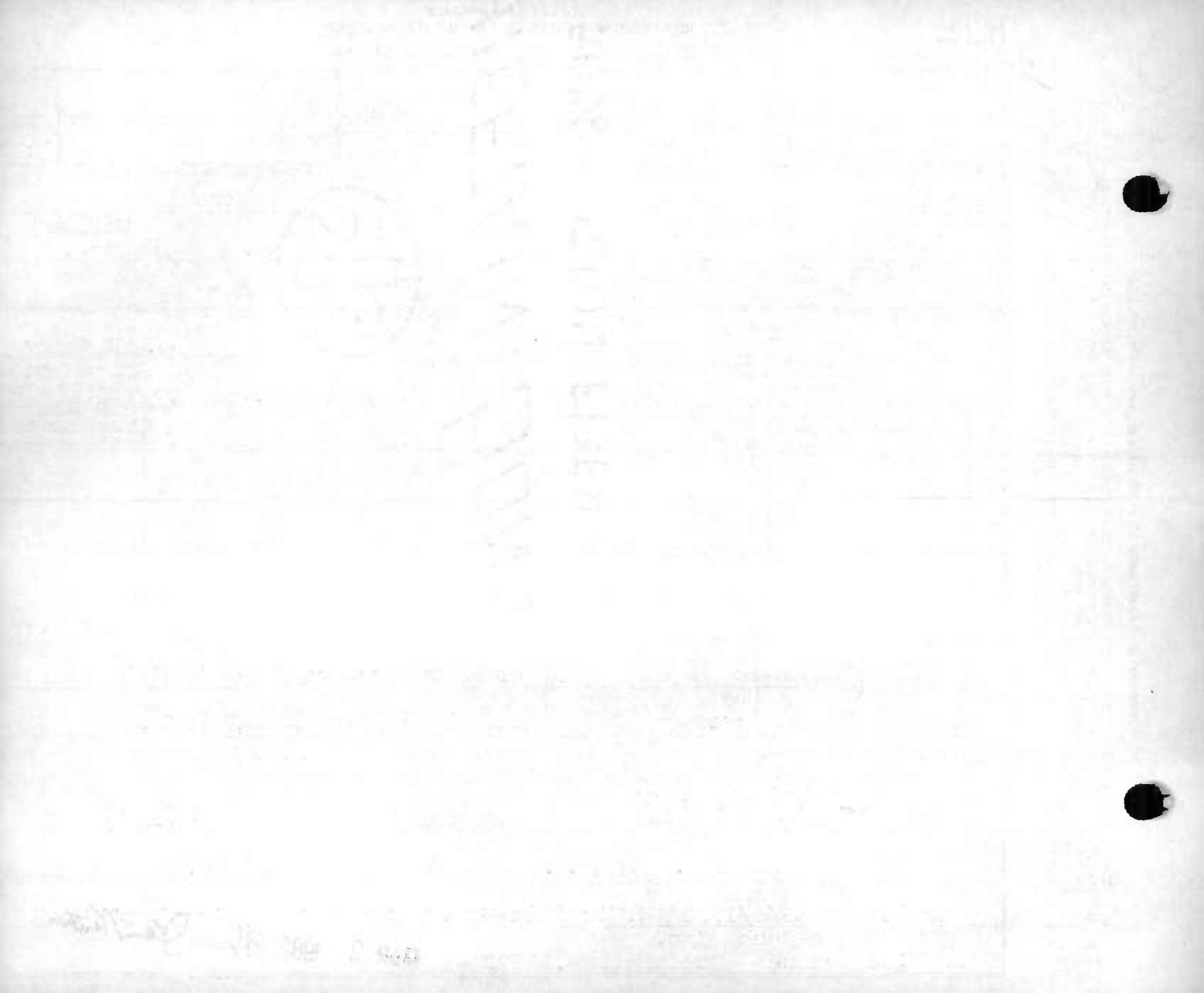
WATER

DHMH-17  
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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

| FOR STATE REGISTRAR   |  |  |  |  |  |  |  |  |  | DEPARTMENT OF HEALTH AND MENTAL HYGIENE                  |  |  |  |  |  |  |  |  |  | MEDICAL EXAMINER'S CERTIFICATE OF DEATH        |  |  |  |  |  |  |  |  |  | REG. NO. 04049           |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                     |  |  |  |  |  |  |  |  |  |                          |  |  |  |  |  |  |  |  |  |          |  |  |  |  |  |  |  |  |  |
|---|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--------------------------|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|---------------------|--|--|--|--|--|--|--|--|--|--------------------------|--|--|--|--|--|--|--|--|--|----------|--|--|--|--|--|--|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT)  |  |  |  |  |  |  |  |  |  | 2a. DATE KNOWN OF DEATH                                  |  |  |  |  |  |  |  |  |  | 2b. HOUR                                       |  |  |  |  |  |  |  |  |  |                          |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                     |  |  |  |  |  |  |  |  |  |                          |  |  |  |  |  |  |  |  |  |          |  |  |  |  |  |  |  |  |  |
| FIRST MIDDLE LAST   |  |  |  |  |  |  |  |  |  | MONTH DAY YEAR   |  |  |  |  |  |  |  |  |  | MONTH DAY YEAR                                 |  |  |  |  |  |  |  |  |  |                          |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                     |  |  |  |  |  |  |  |  |  |                          |  |  |  |  |  |  |  |  |  |          |  |  |  |  |  |  |  |  |  |
| John David Mullins, Jr.   |  |  |  |  |  |  |  |  |  | 2  |  |  |  |  |  |  |  |  |  | 27   |  |  |  |  |  |  |  |  |  | 1982                     |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                     |  |  |  |  |  |  |  |  |  |                          |  |  |  |  |  |  |  |  |  |          |  |  |  |  |  |  |  |  |  |
| 3. SEX male   |  |  |  |  |  |  |  |  |  | 4. RACE white  |  |  |  |  |  |  |  |  |  | 5. DATE OF BIRTH                               |  |  |  |  |  |  |  |  |  | 6. AGE (IN YEARS)        |  |  |  |  |  |  |  |  |  | IF UNDER 1 YR.                         |  |  |  |  |  |  |  |  |  | IF UNDER 24 HRS.    |  |  |  |  |  |  |  |  |  | 2c. DATE PRONOUNCED DEAD |  |  |  |  |  |  |  |  |  | 2d. HOUR |  |  |  |  |  |  |  |  |  |
| MONTH DAY YEAR  |  |  |  |  |  |  |  |  |  | MONTH DAY YEAR   |  |  |  |  |  |  |  |  |  | MONTHS DAYS HOURS MIN                          |  |  |  |  |  |  |  |  |  | MONTH DAY YEAR           |  |  |  |  |  |  |  |  |  | MONTH DAY YEAR                         |  |  |  |  |  |  |  |  |  | MONTH DAY YEAR      |  |  |  |  |  |  |  |  |  | MONTH DAY YEAR           |  |  |  |  |  |  |  |  |  |          |  |  |  |  |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH   |  |  |  |  |  |  |  |  |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION |  |  |  |  |  |  |  |  |  | 12a. USUAL OCCUPATION                          |  |  |  |  |  |  |  |  |  | 12b. IND OF BUSINESS     |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                     |  |  |  |  |  |  |  |  |  |                          |  |  |  |  |  |  |  |  |  |          |  |  |  |  |  |  |  |  |  |
| Baltimore   |  |  |  |  |  |  |  |  |  | University Hospital                                      |  |  |  |  |  |  |  |  |  | Serviceman                                     |  |  |  |  |  |  |  |  |  | Machine Corp.            |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                     |  |  |  |  |  |  |  |  |  |                          |  |  |  |  |  |  |  |  |  |          |  |  |  |  |  |  |  |  |  |
| 13a. STATE  |  |  |  |  |  |  |  |  |  | 13b. COUNTY  |  |  |  |  |  |  |  |  |  | 13c. CITY OR TOWN                              |  |  |  |  |  |  |  |  |  | 13d. INSIDE CITY LIMITS? |  |  |  |  |  |  |  |  |  | 13e. STREET ADDRESS                    |  |  |  |  |  |  |  |  |  |                     |  |  |  |  |  |  |  |  |  |                          |  |  |  |  |  |  |  |  |  |          |  |  |  |  |  |  |  |  |  |
| Maryland  |  |  |  |  |  |  |  |  |  | Baltimore  |  |  |  |  |  |  |  |  |  | Dundalk  |  |  |  |  |  |  |  |  |  | YES NO                   |  |  |  |  |  |  |  |  |  | 1656 Gray Place                        |  |  |  |  |  |  |  |  |  |                     |  |  |  |  |  |  |  |  |  |                          |  |  |  |  |  |  |  |  |  |          |  |  |  |  |  |  |  |  |  |
| 14. FATHER'S NAME   |  |  |  |  |  |  |  |  |  | 15. MOTHER'S MAIDEN NAME                                 |  |  |  |  |  |  |  |  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?   |  |  |  |  |  |  |  |  |  | 16b. SOCIAL SECURITY NO. |  |  |  |  |  |  |  |  |  | 17. INFORMANT                          |  |  |  |  |  |  |  |  |  | ADDRESS             |  |  |  |  |  |  |  |  |  |                          |  |  |  |  |  |  |  |  |  |          |  |  |  |  |  |  |  |  |  |
| John D. Mullins, Sr.  |  |  |  |  |  |  |  |  |  | Rena M. Salisbury  |  |  |  |  |  |  |  |  |  | Yes 1980-                                      |  |  |  |  |  |  |  |  |  | 216-72-7365              |  |  |  |  |  |  |  |  |  | John D. Mullins, Sr.-Balto., MD. 21222 |  |  |  |  |  |  |  |  |  | 1656 Gray Place     |  |  |  |  |  |  |  |  |  |                          |  |  |  |  |  |  |  |  |  |          |  |  |  |  |  |  |  |  |  |
| 18. CAUSE OF DEATH  |  |  |  |  |  |  |  |  |  | 19. CONDITION FOR WHICH OPERATION WAS PERFORMED?         |  |  |  |  |  |  |  |  |  | 20. AUTOPSY?                                   |  |  |  |  |  |  |  |  |  |                          |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                     |  |  |  |  |  |  |  |  |  |                          |  |  |  |  |  |  |  |  |  |          |  |  |  |  |  |  |  |  |  |
| PART 1 DEATH WAS CAUSED BY:   |  |  |  |  |  |  |  |  |  | IMMEDIATE CAUSE (a)                                      |  |  |  |  |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |  |  |  |  |  |  |  |  |                          |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                     |  |  |  |  |  |  |  |  |  |                          |  |  |  |  |  |  |  |  |  |          |  |  |  |  |  |  |  |  |  |
| 8123  |  |  |  |  |  |  |  |  |  | Multiple injuries  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                          |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                     |  |  |  |  |  |  |  |  |  |                          |  |  |  |  |  |  |  |  |  |          |  |  |  |  |  |  |  |  |  |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.                                       |  |  |  |  |  |  |  |  |  | (b)  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                          |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                     |  |  |  |  |  |  |  |  |  |                          |  |  |  |  |  |  |  |  |  |          |  |  |  |  |  |  |  |  |  |
|   |  |  |  |  |  |  |  |  |  | (c)  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                          |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                     |  |  |  |  |  |  |  |  |  |                          |  |  |  |  |  |  |  |  |  |          |  |  |  |  |  |  |  |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                          |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                     |  |  |  |  |  |  |  |  |  |                          |  |  |  |  |  |  |  |  |  |          |  |  |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  |  |  |  |  |  |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?        |  |  |  |  |  |  |  |  |  | 20. AUTOPSY?                                   |  |  |  |  |  |  |  |  |  |                          |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                     |  |  |  |  |  |  |  |  |  |                          |  |  |  |  |  |  |  |  |  |          |  |  |  |  |  |  |  |  |  |
| 21a. EXTERNAL CAUSE WAS   |  |  |  |  |  |  |  |  |  | 21b. TIME OF INJURY                                      |  |  |  |  |  |  |  |  |  | 21c. HOW INJURY OCCURRED                       |  |  |  |  |  |  |  |  |  |                          |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                     |  |  |  |  |  |  |  |  |  |                          |  |  |  |  |  |  |  |  |  |          |  |  |  |  |  |  |  |  |  |
| UNDERLYING OR CONTRIBUTING CAUSE OF DEATH   |  |  |  |  |  |  |  |  |  | 8:00XX 2/26 1982   |  |  |  |  |  |  |  |  |  | auto passenger on motorcycle in collision with |  |  |  |  |  |  |  |  |  |                          |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                     |  |  |  |  |  |  |  |  |  |                          |  |  |  |  |  |  |  |  |  |          |  |  |  |  |  |  |  |  |  |
| 21d. INJURY OCCURRED  |  |  |  |  |  |  |  |  |  | 21e. PLACE OF INJURY                                     |  |  |  |  |  |  |  |  |  | 21f. LOCATION                                  |  |  |  |  |  |  |  |  |  |                          |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                     |  |  |  |  |  |  |  |  |  |                          |  |  |  |  |  |  |  |  |  |          |  |  |  |  |  |  |  |  |  |
| WHILE NOT WHILE AT WORK   |  |  |  |  |  |  |  |  |  | roadway  |  |  |  |  |  |  |  |  |  | NorthPoint Blvd & Norris Lane, Balto Co, MD    |  |  |  |  |  |  |  |  |  |                          |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                     |  |  |  |  |  |  |  |  |  |                          |  |  |  |  |  |  |  |  |  |          |  |  |  |  |  |  |  |  |  |
| 22a. I certify that I took charge of the remains described above, held on   |  |  |  |  |  |  |  |  |  | Autopsy XX   |  |  |  |  |  |  |  |  |  | Inspection                                     |  |  |  |  |  |  |  |  |  | Inquiry                  |  |  |  |  |  |  |  |  |  | and in my opinion                      |  |  |  |  |  |  |  |  |  |                     |  |  |  |  |  |  |  |  |  |                          |  |  |  |  |  |  |  |  |  |          |  |  |  |  |  |  |  |  |  |
| death resulted from:  |  |  |  |  |  |  |  |  |  | Natural causes   |  |  |  |  |  |  |  |  |  | Accident XX                                    |  |  |  |  |  |  |  |  |  | Suicide                  |  |  |  |  |  |  |  |  |  | Homicide                               |  |  |  |  |  |  |  |  |  | Undetermined manner |  |  |  |  |  |  |  |  |  |                          |  |  |  |  |  |  |  |  |  |          |  |  |  |  |  |  |  |  |  |
| ACTUAL SIGNATURE  |  |  |  |  |  |  |  |  |  | TITLE (SPECIFY)  |  |  |  |  |  |  |  |  |  | DATE SIGNED                                    |  |  |  |  |  |  |  |  |  |                          |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                     |  |  |  |  |  |  |  |  |  |                          |  |  |  |  |  |  |  |  |  |          |  |  |  |  |  |  |  |  |  |
| Hormez R. Guard, M.D.   |  |  |  |  |  |  |  |  |  | Assistant  |  |  |  |  |  |  |  |  |  | 2/28/82  |  |  |  |  |  |  |  |  |  |                          |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                     |  |  |  |  |  |  |  |  |  |                          |  |  |  |  |  |  |  |  |  |          |  |  |  |  |  |  |  |  |  |
| EXAMINER'S NAME (TYPE OR PRINT)   |  |  |  |  |  |  |  |  |  | ADDRESS  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                          |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                     |  |  |  |  |  |  |  |  |  |                          |  |  |  |  |  |  |  |  |  |          |  |  |  |  |  |  |  |  |  |
| Hormez R. Guard, M.D.   |  |  |  |  |  |  |  |  |  | 111 Penn Street, Balto. MD 21201                         |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                          |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                     |  |  |  |  |  |  |  |  |  |                          |  |  |  |  |  |  |  |  |  |          |  |  |  |  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |  |  |  |  |  |  |  |  |  | 23b. DATE  |  |  |  |  |  |  |  |  |  | 23c. NAME OF CEMETERY OR CREMATORY             |  |  |  |  |  |  |  |  |  | 23d. LOCATION            |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                     |  |  |  |  |  |  |  |  |  |                          |  |  |  |  |  |  |  |  |  |          |  |  |  |  |  |  |  |  |  |
| Burial  |  |  |  |  |  |  |  |  |  | 3/5/1982   |  |  |  |  |  |  |  |  |  | W. Virginia, Mem. Gdns                         |  |  |  |  |  |  |  |  |  | Calvin Nicholas          |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                     |  |  |  |  |  |  |  |  |  |                          |  |  |  |  |  |  |  |  |  |          |  |  |  |  |  |  |  |  |  |
| 24. FUNERAL DIRECTOR  |  |  |  |  |  |  |  |  |  | 25a. DATE REC'D. BY REGISTRAR                            |  |  |  |  |  |  |  |  |  | 25b. REGISTRAR'S SIGNATURE                     |  |  |  |  |  |  |  |  |  |                          |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                     |  |  |  |  |  |  |  |  |  |                          |  |  |  |  |  |  |  |  |  |          |  |  |  |  |  |  |  |  |  |
| NAME ADDRESS  |  |  |  |  |  |  |  |  |  | MAR 2 1982   |  |  |  |  |  |  |  |  |  | Francis  |  |  |  |  |  |  |  |  |  |                          |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                     |  |  |  |  |  |  |  |  |  |                          |  |  |  |  |  |  |  |  |  |          |  |  |  |  |  |  |  |  |  |
| 7922 Wise Avenue Dundalk, MD. 21222   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                          |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                     |  |  |  |  |  |  |  |  |  |                          |  |  |  |  |  |  |  |  |  |          |  |  |  |  |  |  |  |  |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  | 8 2 0 4 0 5 0   |  |  |  |
|---|--|---|--|---|--|--|--|
| 1. FOR STATE REGISTRAR  |  |   |  | REG. NO.  |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>MYRTLE M. MUNCY</b>  |  |   |  | 2a. DATE OF DEATH   |  | 2b. HOUR   |  |
|   |  |   |  | MONTH DAY YEAR<br><b>2 27 82</b>  |  | 12 <sup>05</sup> PM  |  |
| 3. SEX<br><b>FEMALE</b>   |  | 4. RACE<br><b>CAUCASIAN</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>5 10 10</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>71</b> YRS.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>KENTUCKY</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>CITY</b> MD.  |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>BON SECOURS HOSP.</b> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>HOMEMAKER</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>---</b>  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |   |  | 12c. STREET ADDRESS<br><b>21223</b>   |  |  |  |
| 13a. STATE<br><b>MD</b>   |  | 13b. COUNTY<br><b>BALTO.</b>  |  | 13c. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 13d. STREET ADDRESS<br><b>324 S. MOUNT ST.</b>   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>CHARLES HYATT</b>  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>ELIZABETH (UNKNOWN)</b>   |  | 16. ADDRESS<br><b>SEVERN, MD. 21144</b>   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>233-70-7886</b>  |  | 17. INFORMANT<br><b>LEROY O. PROPST</b> ADDRESS<br><b>1160 THOMPSON AVENUE</b>  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>4960 ACUTE RESPIRATORY FAILURE</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>CHRONIC OBSTRUCTIVE PULMO-NARY DISEASE</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>ASCVD-CHF.</b><br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>ASCVD-CHF.</b> |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>6 DAYS</b><br><b>YEARS</b>   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>2-21</b> , 19 <b>82</b> , to <b>2-27</b> , 19 <b>82</b> , that (I) (we) lost saw the deceased alive on <b>2-27</b> , 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |   |  |   |  |  |  |
| 22b. SIGNATURE<br><b>Oscar E. Ferdinandini M.D.</b>   |  |   |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>        |  | 22c. DATE SIGNED<br><b>2-27-82</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>OSCAR E. FERNANDINI</b>   |  |   |  | 22e. ADDRESS<br><b>2000 W. BALTO. ST. BALTO. MD. 21223</b>  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>   |  | 23b. DATE<br><b>03-02-82</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>GLEN HAVEN MEM. PARK</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>GLEN BURNIE BALTO. MARYLAND</b>   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>HUBBARD FUNERAL HOME, INC.</b>   |  |   |  | ADDRESS<br><b>4107 WILKENS AVE.</b>   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>MAR 1 1982</b>   |  |

WISCONSIN  
JANUARY 2 1964  
FARMER  
STATE OF WISCONSIN  
COUNTY OF [illegible]  
[illegible]

TO THE HONORABLE  
CLERK OF THE CIRCUIT COURT  
IN AND FOR THE COUNTY OF [illegible]  
STATE OF WISCONSIN  
I, [illegible], of the County of [illegible], State of Wisconsin, do hereby certify that [illegible]

WITNESSED my hand and the seal of said Court this [illegible] day of [illegible] 1964.  
[illegible]  
[illegible]

DEPT. OF REVENUE  
MADISON, WISCONSIN  
JAN 1 1964  
[illegible]

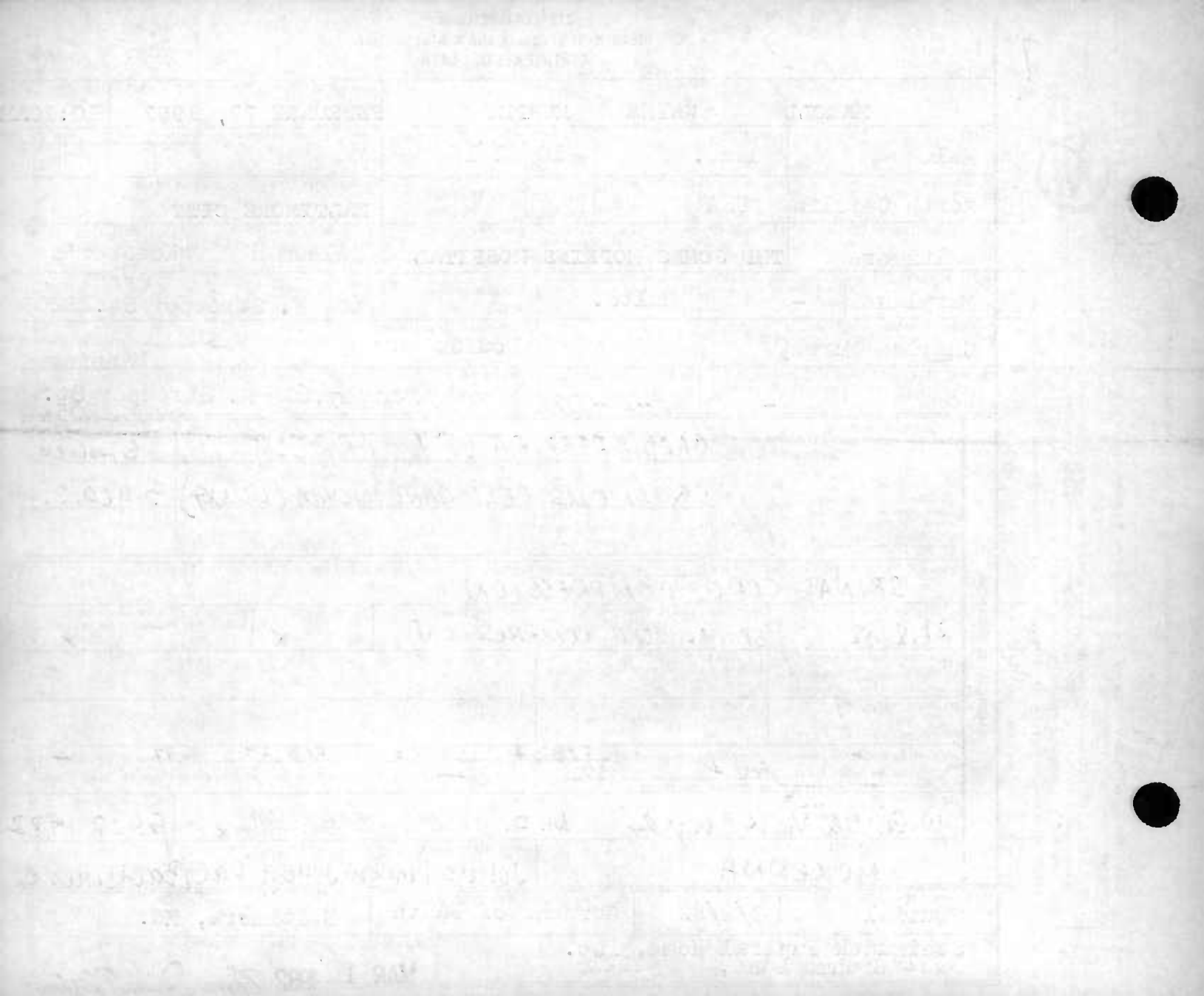


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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |   |  |                                    |  |                |   |  |
|--|--|--|---|--|------------------------------------|--|----------------|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  |  | 2a. DATE OF DEATH   |  |                                    | 2b. HOUR   |                |   |  |
| HAROLD WAYNE MURPHY  |  |  | FEBRUARY 27, 1982   |  |                                    | 10:10AM  |                |   |  |
| 3. SEX   | 4. RACE  | 5. DATE OF BIRTH   | 6. AGE (IN YEARS-LAST BIRTHDAY)                                     |  |                                    | 7. IF UNDER 1 YEAR   |                |   |  |
| Male   | Cauc.  | 10/22/15   | 66  |  |                                    | MONTHS DAYS HOURS MIN.   |                |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  | 7b. CITIZEN OF WHAT COUNTRY?   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |  |                                    | 10. BALTIMORE CITY MD.   |                |   |  |
| North Carolina   | USA  |  | BALTIMORE CITY  |  |                                    |  |                |   |  |
| 11. CITY OR TOWN OF DEATH  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)       |  |                                    | 12b. KIND OF BUSINESS OR INDUSTRY  |                |   |  |
| Baltimore  | THE JOHNS HOPKINS HOSPITAL   |  | Salesman  |  |                                    | Koester's Baker y  |                |   |  |
| 13a. STATE   | 13b. COUNTY  | 13c. CITY OR TOWN  | 13d. INSIDE CITY LIMITS?  |  |                                    | 13e. STREET ADDRESS  |                |   |  |
| Maryland   | -  | Balto.   | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |                                    | 604 N. Streeper St. 21205  |                |   |  |
| 14. FATHER'S NAME  |  |  | 15. MOTHER'S MAIDEN NAME  |  |                                    | 16. ADDRESS  |                |   |  |
| Charles Murphy   |  |  | Louise Manning  |  |                                    |  |                |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)  |  |  | 16b. SOCIAL SECURITY NO.  |  |                                    | 17. INFORMANT  |                |   |  |
| No   |  |  | 246-18-0328   |  |                                    | Dorothy Murphy, 604 N. Streeper St. #21205                                     |                |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |  |  |   |  |                                    |  |                | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                        |  |
| PART I. DEATH WAS CAUSED BY:   |  |  |   |  |                                    |  |                |   |  |
| IMMEDIATE CAUSE (a) CARDIORESPIRATORY ARREST   |  |  |   |  |                                    |  |                | SWING   |  |
| 1629 DUE TO, OR AS A CONSEQUENCE OF  |  |  |   |  |                                    |  |                | 3 years.  |  |
| (b) SQUAMOUS CELL CARCINOMA (LUNG)   |  |  |   |  |                                    |  |                |   |  |
| DUE TO, OR AS A CONSEQUENCE OF   |  |  |   |  |                                    |  |                |   |  |
| (c)  |  |  |   |  |                                    |  |                |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: SPINAL CORD COMPRESSION.  |  |  |   |  |                                    |  |                |   |  |
| 19a. DATE OF OPERATION   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                    |  |                                    | 20a. AUTOPSY?  |                | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?      |  |
| 21/12/82   |  |  | SPINAL CORD COMPRESSION   |  |                                    | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |                | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  | 21b. TIME OF INJURY   |  |                                    | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |                |   |  |
|  |  |  | HOUR A.M. MONTH DAY YEAR  |  |                                    |  |                |   |  |
| 21d. INJURY OCCURRED   |  |  | 21e. PLACE OF INJURY  |  |                                    | 21f. LOCATION  |                |   |  |
| WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  |  | [AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.]                      |  |                                    | CITY OR TOWN COUNTY STATE  |                |   |  |
| 22a. I certify that (this hospital) attended the deceased from Feb 4, 1982, to Feb 27, 1982, that (I) saw the deceased alive on Feb 4, 1982, and that in (my) opinion death occurred on the date and hour and from the causes stated above, (I) (did) (did not) view the body after death. |  |  |   |  |                                    |  |                |   |  |
| 22b. SIGNATURE   |  |  | DEGREE  |  |                                    | 22c. DATE SIGNED   |                |   |  |
| W. GILES MCKENNA   |  |  | M.D.  |  |                                    | Feb 27 1982  |                |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  |  | 22e. ADDRESS  |  |                                    |  |                |   |  |
| MCKENNA  |  |  | Johns Hopkins Hospital, Baltimore                                   |  |                                    |  |                |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  |  | 23b. DATE   |  | 23c. NAME OF CEMETERY OR CREMATORY |  | 23d. LOCATION  |   |  |
| Burial   |  |  | 3/2/82  |  | Gardens of Faith                   |  | Baltimore, Md. |   |  |
| 24. FUNERAL DIRECTOR   |  |  |   |  |                                    | 25a. DATE REC'D. BY REGISTRAR  |                | 25b. REGISTRAR'S SIGNATURE  |  |
| Schimunek Funeral Home, Inc. 3331 Brehms Lane, #21213  |  |  |   |  |                                    | MAR 1 1982   |                | James Van N...  |  |



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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |   |  |                                   |   |  |   |  |          |
|---|--|--|---|--|-----------------------------------|---|--|---|--|----------|
| 1. FOR STATE REGISTRAR  |  | REG. NO.   |   |  |                                   |   |  |   |  |          |
| 1. DECEASED NAME (TYPE OR PRINT)  |  | FIRST  |   | MIDDLE   |                                   | LAST  |  | 2a. DATE OF DEATH MONTH DAY YEAR  |  | 2b. HOUR |
| JOSEPH PATRICK MURPHY   |  |  |   |  |                                   |   |  | 2/24/82   |  | 1:45 AM  |
| 3. SEX  | 4. RACE  | 5. DATE OF BIRTH MONTH DAY YEAR  |   | 6. AGE (IN YEARS LAST BIRTHDAY)  |                                   | IF UNDER 1 YEAR MONTHS DAYS   |  | IF UNDER 24 HRS. HOURS MIN.   |  |          |
| Male  | White  | 1 25 26  |   | 56   |                                   |   |  |   |  |          |
| 7a. BIRTHPLACE (COUNTRY)  | 7b. CITIZEN OF WHAT COUNTRY?   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH   |                                   |   |  |   |  |          |
| IRELAND   | U.S.A.   |  |   | Baltimore City MD.   |                                   |   |  |   |  |          |
| 10. CITY OR TOWN OF DEATH   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) |  | 12b. KIND OF BUSINESS OR INDUSTRY |   |  |   |  |          |
| Baltimore   | St. Agnes  |  | City Councilman   |  |                                   |   |  |   |  |          |
| 13a. STATE  |  | 13b. COUNTY  | 13c. CITY OR TOWN   | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS               |   |  |   |  |          |
| MD  |  |  | Balt  |  | 3380 BENEDICT ST                  |   |  |   |  |          |
| 14. FATHER'S NAME FIRST MIDDLE LAST   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST   |   |  |                                   |   |  |   |  |          |
| DANIEL - MURPHY   |  | CATHERINE Irene Kavanaugh  |   |  |                                   |   |  |   |  |          |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES <input type="checkbox"/> UNKNOWN <input type="checkbox"/> IF YES, GIVE WAR OR DATES)  |  | 16b. SOCIAL SECURITY NO.   |   | 17. INFORMANT  |                                   | ADDRESS   |  |   |  |          |
| 6-43 to 3-46  |  | 219-6-8229   |   | Mrs. Joan Murphy   |                                   | 3380 St. Benedict Street 21229  |  |   |  |          |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:   |  |  |   |  |                                   |   |  |   |  |          |
| IMMEDIATE CAUSE (a) 4100 CARDIAC ARREST   |  |  |   |  |                                   |   |  |   |  |          |
| DUE TO, OR AS A CONSEQUENCE OF (b) MYOCARDIAL INFARCTION  |  |  |   |  |                                   |   |  |   |  |          |
| DUE TO, OR AS A CONSEQUENCE OF (c)  |  |  |   |  |                                   |   |  |   |  |          |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a):   |  |  |   |  |                                   |   |  |   |  |          |
| CORONARY CHRONIC RA - HEART DISEASE   |  |  |   |  |                                   |   |  |   |  |          |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   |  |                                   | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |          |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)               |                                   |   |  |   |  |          |
|   |  | P.M. 19  |   |  |                                   |   |  |   |  |          |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |                                   |   |  |   |  |          |
|   |  |  |   |  |                                   |   |  |   |  |          |
| 22a. I certify that (I) (this hospital) attended the deceased from 2-13-82 to 2-24-82, that (I) (we) last saw the deceased alive on 2-24-82, and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |   |  |                                   |   |  |   |  |          |
| 22b. SIGNATURE  |  | DEGREE   |   | 22c. DATE SIGNED   |                                   |   |  |   |  |          |
| Geetha Raja MD  |  | RESIDENT   |   | 2-24-82  |                                   |   |  |   |  |          |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  | 22e. ADDRESS   |   |  |                                   |   |  |   |  |          |
| GEETHA RAJA   |  | 900, Caven Ave, Baltimore Md-21229   |   |  |                                   |   |  |   |  |          |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |  | 23b. DATE  |   | 23c. NAME OF CEMETERY OR CREMATORY   |                                   | 23d. LOCATION CITY OR TOWN COUNTY STATE   |  |   |  |          |
| Cremation   |  | 2-26-82  |   | Loudon Park Cem.   |                                   | Balto. Md.  |  |   |  |          |
| 24. FUNERAL DIRECTOR  |  | 25a. DATE REC'D. BY REGISTRAR  |   | 25b. REGISTRAR'S SIGNATURE   |                                   |   |  |   |  |          |
| G. Truman Schwab, P.A.  |  | MAR 1 1982   |   | [Signature]  |                                   |   |  |   |  |          |
|   |  | 3512 Frederick Ave., 21229   |   |  |                                   |   |  |   |  |          |



TD HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Dead may be retained by the hospital or attending physician.

TD FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  | REG. NO. 8 2 0 4 0 5 3  |  |   |  |
|---|--|--|--|---|--|---|--|
| 1. FOR STATE REGISTRAR  |  | 1. DECEASED NAME (TYPE OR PRINT)   |  | 2a. DATE OF DEATH   |  | 2b. HOUR  |  |
|   |  | EDNA MURRAY  |  | Feb. 9, 1982  |  | 11:50 AM  |  |
| 3 SEX   |  | 4 RACE   |  | 5 DATE OF BIRTH   |  | 6 AGE (IN YEARS LAST BIRTHDAY)                                      |  |
| female  |  | Black  |  | 7/6/1918  |  | 63  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |  |
| Maryland  |  | USA  |  |   |  | Baltimore City MD.  |  |
| 10 CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)   |  | 12b. KIND OF BUSINESS OR INDUSTRY                                   |  |
| Baltimore   |  | 4302 Conn. Ave.  |  | Domestic  |  |   |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  | 13b. COUNTY  |  | 13c. CITY OR TOWN   |  | 13d. INSIDE CITY LIMITS?  |  |
| Md.   |  | Kent   |  | Rock Hall   |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 14 FATHER'S NAME  |  | 15. MOTHER'S MAIDEN NAME   |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)   |  | 16b. SOCIAL SECURITY NO.  |  |
| Foster White  |  | Georgia Sisco  |  | no  |  | 219 07 6824   |  |
| 17. INFORMANT   |  | ADDRESS  |  | 17. INFORMANT   |  | ADDRESS   |  |
| Charles Feagin  |  | 4302 Ct. Ave.  |  | Charles Feagin  |  | Baltimore, Md.  |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardiopulmonary arrest</u>   |  |  |  |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| 1539  |  |  |  |   |  |   |  |
| DUE TO, OR AS A CONSEQUENCE OF (b) <u>Metastatic adenocarcinoma, colon</u>  |  |  |  |   |  |   |  |
| DUE TO, OR AS A CONSEQUENCE OF (c)  |  |  |  |   |  |   |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)  |  |  |  |   |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?      |  |
| 12/23/81  |  | Intestinal obstruction, colon cancer   |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | YES <input type="checkbox"/> NO <input type="checkbox"/>            |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |
|   |  | HOUR A.M. MONTH DAY YEAR   |  |   |  |   |  |
|   |  | P.M. 19  |  |   |  |   |  |
| 21d. INJURY OCCURRED  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  | 21f. LOCATION   |  |   |  |
| WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  |  |  | STREET CITY OR TOWN COUNTY STATE  |  |   |  |
| 22. I certify that (I) (this hospital) attended the deceased from <u>Oct. 19 80</u> to <u>2/9 19 82</u> , that (I) (we) last saw the deceased alive on <u>1/28 19 82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |   |  |   |  |
| 27b. SIGNATURE  |  | DEGREE   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>              |  | 22c. DATE SIGNED  |  |
| William A. Scovill M.D.   |  |  |  |   |  | 2/9/82  |  |
| 27d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  | 27e. ADDRESS   |  | 27f. DATE REC'D. BY REGISTRAR   |  | 27g. REGISTRAR'S SIGNATURE  |  |
| William A. Scovill  |  | University of Maryland Hospital  |  | FEB 16 1982   |  | James J. [Signature]  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY  |  | 23d. LOCATION   |  |
| Burial  |  | 2/13/82  |  | Sharptown Cem. near Rock Hall, Md.  |  | CITY OR TOWN COUNTY STATE   |  |
| 27. FUNERAL DIRECTOR  |  | ADDRESS  |  | 27. DATE REC'D. BY REGISTRAR  |  | 27. REGISTRAR'S SIGNATURE   |  |
| James Perkins   |  | Rock Hall, Md.   |  | FEB 16 1982   |  | James J. [Signature]  |  |





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 4 0 5 4

REG. NO.

|  |  |   |  |  |  |   |  |  |
|--|--|---|--|--|--|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br><b>Arthur MYERS JR</b>  |  |   | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>2 14 82</b> |  |  | 2b. HOUR<br><b>1236AM</b>   |  |  |
| 3 SEX<br><b>M</b>  |  | 4. RACE<br><b>B</b>   |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>09 29 23</b>   |  | 6 AGE (IN YEARS (LAST BIRTHDAY))<br><b>58</b> YRS.  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Md</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A</b>  |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>City</b> MD.  |  |  |
| 10 CITY OR TOWN OF DEATH<br><b>BALTO</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>University Hosp</b> |  |  |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)                                |  |  |
| 13a. STATE<br><b>Md</b>  |  | 13b. COUNTY   |  | 13c. CITY OR TOWN<br><b>BALTO</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 14 FATHER'S NAME FIRST MIDDLE LAST<br><b>Arthur MYERS</b>  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Matilda Hedges</b>   |  | 13e. STREET ADDRESS<br><b>934 Bennett Pl</b>   |  |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>—</b>  |  | 17. INFORMANT ADDRESS<br><b>VIO/A BROWN 934 Bennett Pl</b>   |  |   |  |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>cardiac arrest</b><br><b>4589</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>hypotension</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(c) <b>—</b><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>30 minutes</b><br><b>1 hr</b> |  |   |  |  |  |   | 18   |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |   |  |  |  |   |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21a. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)   |  |   |  |  |
| 21b. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21d. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>2/12</b> , 19 <b>82</b> , to <b>2/14</b> , 19 <b>82</b> , that (I) (we) lost saw the deceased alive on <b>2/14</b> , 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.   |  |   |  |  |  |   |  |  |
| 22b. SIGNATURE<br><b>Edward S. Beaman</b>  |  | DEGREE<br><b>MD</b>   |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>                 |  | 22c. DATE SIGNED<br><b>2/14/82</b>  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>BEAMAN</b>   |  | 22e. ADDRESS<br><b>University Hospital</b>  |  |  |  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>2/18/82</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Cedar Hill</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>BALTO MD</b>                                   |  |  |
| 24 FUNERAL DIRECTOR<br>NAME<br><b>Vernon R. Bailey</b>   |  | ADDRESS<br><b>1348 N. Calhoun St</b>  |  | 25. DATE REC'D BY REGISTRAR<br><b>FEB 16 1982</b>  |  |   |  |  |

MEDICAL CERTIFICATION





TO HOSPITAL OR ATTENDING PHYSICIAN: This certificate is to be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with the funeral director's office. It should be removed from the file within 72 hours of the death.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of one.

DHMH-16 50M 1/81  
(VRA 15, 4)

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |                              |  | REG. NO.  |  |  |  |
|--|--|------------------------------|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Woodrow Myrick</b>   |  |                              |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>2-19-82</b>   |  |  |  |
| 3 SEX<br><b>MALE</b>   |  |                              |  | 4. RACE<br><b>NEGRO</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>JAN 10 1914</b>   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>NORTH CAROLINA</b>   |  |                              |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>68</b> YRS.  |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>  |  |                              |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>John Hopkins Hospital</b> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.  |  |
| 13a. STATE<br><b>MARYLAND</b>  |  |                              |  | 13b. COUNTY<br><b>BALTIMORE</b>   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>COOK</b>  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>JAMES MYRICK</b>  |  |                              |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>unk</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>RESTAURANT</b>   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>NO</b>  |  |                              |  | 16b. SOCIAL SECURITY NO.<br><b>213-05-2803A</b>   |  | 17. INFORMANT<br>ADDRESS<br><b>BERTHA MYRICK/2205 HOMEWOOD AVE</b>   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>cardiopulmonary arrest</b><br>4860<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>pneumonia</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>30 min.</b><br>?<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)<br><b>Parkinson's Disease</b> |  |                              |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  |                              |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                       |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |                              |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>2:15 P.M. 19 82</b>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21d. INJURY OCCURRED<br>WHERE <input type="checkbox"/> NOT WHERE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  |                              |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)   |  |
| 22a. I certify that (1) this hospital attended the deceased from <b>2/19 1982</b> , to <b>2/19 1982</b> , that (1) (we) last saw the deceased alive on <b>2/19 1982</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we did not view the body after death, so state.)  |  |                              |  |   |  |  |  |
| 22b. SIGNATURE<br><b>H. G. Jones</b>   |  |                              |  | DEGREE  |  | 22c. DATE SIGNED<br><b>2/19/82</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>HILARY STEDMAN</b>   |  |                              |  | 22e. ADDRESS<br><b>JOHN HOPKINS HOSPITAL, BALTIMORE</b>   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>BURIAL</b>   |  | 23b. DATE<br><b>02/25/82</b> |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>ARBUTUS MEM PARK</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>ARBUTUS BALTO. MD.</b>  |  |
| 24. FUNERAL DIRECTOR<br><b>MARSHALL W JONES, JR/4101</b>   |  |                              |  | 25a. DATE REC'D. BY REGISTRAR<br><b>FEB 25 1982</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>James J. [Signature]</b>  |  |

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 NARUTOWICZ, MARY  
08/31/82, 56

1- FOR  
STATE  
REGISTRAR

REG. NO.

|   |  |   |  |   |
|---|--|---|--|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Mary Magdalena NARUTOWICZ</b>           |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>2 11 82</b>   |  | 2b. HOUR<br><b>3:42 A.M.</b>  |
| 3. SEX<br><b>Female</b>   | 4. RACE<br><b>Caucasian</b>  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>12 24 1898</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>83</b> YRS.   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>N.Y.</b>                          | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore</b> MD.                                    |
| 10. CITY OR TOWN OF DEATH<br><b>Balto</b>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Baltimore City Hospitals</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>homemaker</b> | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>home</b>  |
| 13a. STATE<br><b>Md.</b>  |  | 13b. COUNTY<br><b>Balto.</b>  | 13c. CITY OR TOWN<br><b>Balto.</b>   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Joseph Vecchiarella</b>              |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>unk</b>   |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>no</b> |  | 16b. SOCIAL SECURITY NO.  |  | 17. INFORMANT<br>ADDRESS<br><b>William Bobac, 123 S. Eaton St.</b>                              |

## 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) **CARDIO RESPIRATORY ARREST**

**2639**  
Conditions, if any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(b) **CACHEXIA**

DUE TO, OR AS A CONSEQUENCE OF

(c) **CHRONIC MALNUTRITION**

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH  
**~ 20 MINUTES**

**2 WEEKS****MONTHS**

## PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):

**STATUS Post EXPL. LAP FOR RELEASE SMALL BOWEL OBSTRUCTION**

|  |  |  |   |
|--|--|--|---|
| 19a. DATE OF OPERATION<br><b>1-9-82</b>  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>Bowel Obstruction</b> | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>            | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)       | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |   |
| 22a. I certify that (I) (the hospital) attended the deceased from <b>1/6</b> , 19 <b>82</b> , to <b>2/11</b> , 19 <b>82</b> , the (I) (we) last<br>saw the deceased alive on <b>2/11/82</b> , 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above. (If the deceased was not viewed after death, so state.) |  |  |   |
| 22b. SIGNATURE<br><b>Robert S. Gale MD</b>   |  | 22c. DATE SIGNED<br><b>2/11/82</b>   |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>CASALE</b>   |  | 22e. ADDRESS<br><b>B. C. H.</b>  |   |

|  |                             |   |   |
|--|-----------------------------|---|---|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>                            | 23b. DATE<br><b>2/13/82</b> | 23c. NAME OF CEMETERY OR CREMATORY<br><b>St. Stanislaus</b> | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore, Md.</b> |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Zannino Funeral Home, 263 S. Conkling St.</b> |                             | 25a. DATE REC'D. BY REGISTRAR<br><b>FEB 16 1982</b>         |   |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death and retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Handwritten notes at the top of the page, including "10/10/10" and "10/10/10".

Handwritten notes in the upper middle section, including "10/10/10" and "10/10/10".

Handwritten notes in the middle section, including "10/10/10" and "10/10/10".

Handwritten notes in the lower middle section, including "10/10/10" and "10/10/10".

Handwritten notes in the lower section, including "10/10/10" and "10/10/10".

Handwritten notes at the bottom of the page, including "10/10/10" and "10/10/10".

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1b. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 48 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH-17  
(VR A15 ME (5))  
15M 2/80

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

|  |         |  |  |   |  |                                    |  |                                      |  |                          |  |  |  |
|--|---------|--|--|---|--|------------------------------------|--|--------------------------------------|--|--------------------------|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |         | FIRST  |  | MIDDLE  |  | LAST                               |  | 2a. DATE KNOWN OF DEATH              |  | X MONTH DAY YEAR         |  | 2b. HOUR                                     |  |
| Benedict Charles Nathewitch Jr.  |         |  |  |   |  |                                    |  | ESTI-MATED                           |  | 2 27 19 82               |  | M  |  |
| 3. SEX   | 4. RACE | 5. DATE OF BIRTH   |  | 6. AGE (IN YEARS)   |  | IF UNDER 1 YR.                     |  | IF UNDER 24 HRS.                     |  | 7c. DATE PRONOUNCED DEAD |  | 2d. HOUR                                     |  |
| male   | white   | 8/1/1952   |  | 29 YRS.   |  | MONTHS DAYS HOURS MIN.             |  |                                      |  | 2 27 19 82               |  | 10:47  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |         | 7b. CITIZEN OF WHAT COUNTRY?                             |  | 8. MARRIED  |  | NEVER MARRIED                      |  | 9. BALTIMORE CITY OR COUNTY OF DEATH |  | AM                       |  | MD.  |  |
| Maryland   |         | U.S.A.   |  | WIDOWED   |  | DIVORCED                           |  | Baltimore City                       |  |                          |  |  |  |
| 10. CITY OR TOWN OF DEATH  |         | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |                                      |  |                          |  |  |  |
| Baltimore  |         | University Hospital                                      |  | Hairdresser   |  | Self employed                      |  |                                      |  |                          |  |  |  |
| 13a. STATE   |         | 13b. COUNTY  |  | 13c. CITY OR TOWN   |  | 13d. INSIDE CITY LIMITS?           |  | 13e. STREET ADDRESS                  |  |                          |  |  |  |
| Maryland   |         | -----  |  | Baltimore   |  | YES X NO                           |  | 923 N. Lovegrove St. 21202           |  |                          |  |  |  |
| 14. FATHER'S NAME  |         | 15. MOTHER'S MAIDEN NAME                                 |  |   |  |                                    |  |                                      |  |                          |  |  |  |
| Benedict Charles Nathewitch, Sr.   |         | Rose Bruno   |  |   |  |                                    |  |                                      |  |                          |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?   |         | 16b. SOCIAL SECURITY NO.                                 |  | 17. INFORMANT   |  | ADDRESS                            |  |                                      |  |                          |  |  |  |
| No   |         | 218.60.3793  |  | Rose B. Nathewitch  |  | 63 Kinship Rd. 21222               |  |                                      |  |                          |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |         |  |  |   |  |                                    |  |                                      |  |                          |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART I DEATH WAS CAUSED BY:  |         |  |  |   |  |                                    |  |                                      |  |                          |  |  |  |
| IMMEDIATE CAUSE (a) <u>Stabwound of chest</u>  |         |  |  |   |  |                                    |  |                                      |  |                          |  |  |  |
| 9560   |         |  |  |   |  |                                    |  |                                      |  |                          |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF   |         |  |  |   |  |                                    |  |                                      |  |                          |  |  |  |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.  |         |  |  |   |  |                                    |  |                                      |  |                          |  |  |  |
| (b)  |         |  |  |   |  |                                    |  |                                      |  |                          |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF   |         |  |  |   |  |                                    |  |                                      |  |                          |  |  |  |
| (c)  |         |  |  |   |  |                                    |  |                                      |  |                          |  |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).  |         |  |  |   |  |                                    |  |                                      |  |                          |  |  |  |
| 19a. DATE OF OPERATION   |         |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?             |  |                                    |  | 20. AUTOPSY?                         |  |                          |  |  |  |
|  |         |  |  |   |  |                                    |  | YES NO XX                            |  |                          |  |  |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH  |         |  |  | 21b. TIME OF INJURY   |  |                                    |  | 21c. HOW INJURY OCCURRED             |  |                          |  |  |  |
|  |         |  |  | 2 PM 2/27 19 82   |  |                                    |  | self inflicted wound                 |  |                          |  |  |  |
| 21d. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK   |         |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)   |  |                                    |  | 21f. LOCATION                        |  |                          |  |  |  |
| XX   |         |  |  | home  |  |                                    |  | 927 N. Lovegrove St, Baltimore, MD   |  |                          |  |  |  |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |         |  |  |   |  |                                    |  |                                      |  |                          |  |  |  |
| ACTUAL SIGNATURE   |         |  |  | TITLE (SPECIFY)   |  |                                    |  | DATE SIGNED                          |  |                          |  |  |  |
| Hormez R. Guard, M.D.  |         |  |  | M.D. Assistant MEDICAL EXAMINER                               |  |                                    |  | 2/28/82                              |  |                          |  |  |  |
| EXAMINER'S NAME (TYPE OR PRINT)  |         |  |  | ADDRESS   |  |                                    |  |                                      |  |                          |  |  |  |
| Hormez R. Guard, M.D.  |         |  |  | 111 Penn Street, Balto., MD 21201                             |  |                                    |  |                                      |  |                          |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |         |  |  | 23b. DATE   |  | 23c. NAME OF CEMETERY OR CREMATORY |  | 23d. LOCATION                        |  | COUNTY                   |  | STATE  |  |
| Entombment   |         |  |  | 3/3/1982  |  | Holy Redeemer Cemetery             |  | Baltimore                            |  | Maryland                 |  |  |  |
| 24. FUNERAL DIRECTOR   |         |  |  | 25a. DATE REC'D. BY REGISTRAR                                 |  | 25b. REGISTRAR'S SIGNATURE         |  |                                      |  |                          |  |  |  |
| Walter Brooks Bradley Inc. Dundalk Md 21222  |         |  |  | MAR 4 1982  |  | Francis J. Nathan                  |  |                                      |  |                          |  |  |  |

1102



RECEIVED  
JAN 10 1871  
LIBRARY

*[Faint, mostly illegible handwritten text covering the page, likely bleed-through from the reverse side.]*



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within four hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  |  |                         |  |   |   |   |  |                    |  |
|--|--|---|--|--|-------------------------|--|---|---|---|--|--------------------|--|
| 1- FOR<br>STATE<br>REGISTRAR   |  | REG. NO.  |  |  |                         |  |   |   |   |  |                    |  |
| 1 DECEASED NAME<br>(TYPE OR PRINT)   |  |   |  |  | 2a DATE OF DEATH        |  |   |   |   | 2b HOUR  |                    |  |
| Rusell J. Naughton   |  |   |  |  | Feb. 5, 1982            |  |   |   |   | 7:45 A.M.  |                    |  |
| 3 SEX  |  | 4 RACE  |  | 5 DATE OF BIRTH  |                         | 6 AGE (IN YEARS LAST BIRTHDAY)   |   | 7 UNDER 1 YEAR  |   | 7 UNDER 24 HRS   |                    |  |
| Male   |  | White   |  | Aug. 3, 1909   |                         | 72   |   | MONTHS  |   | DAYS   |                    |  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  | 7b CITIZEN OF WHAT COUNTRY?   |  | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                         | 9 BALTIMORE CITY OR COUNTY OF DEATH  |   |   |   |  |                    |  |
| Wash., D. C.   |  | U. S. A.  |  |  |                         | Baltimore City, MD.  |   |   |   |  |                    |  |
| 10 CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |  |                         | 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)                |   |   | 12b INDUSTRY  |  |                    |  |
| Baltimore  |  | 25 N. Rose Street   |  |  |                         | Worker   |   |   | Tel. Equip.   |  |                    |  |
| 13a STATE  |  |   |  |  | 13b COUNTY              |  | 13c CITY OR TOWN  |   | 13d INSIDE CITY LIMITS?   |  | 13e STREET ADDRESS |  |
| Md.  |  |   |  |  | ---                     |  | Baltimore   |   | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 25 N. Rose Street  |  |
| 14 FATHER'S NAME   |  |   |  |  | 15 MOTHER'S MAIDEN NAME |  |   |   |   |  |                    |  |
| James Naughton   |  |   |  |  | Myrtle O. Naughton      |  |   |   |   |  |                    |  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)  |  |   |  |  | 16b SOCIAL SECURITY NO. |  | 17 INFORMANT  |   |   |  |                    |  |
| Yes-WW II-USN  |  |   |  |  | 216-03-0319             |  | Balto., Md.-21224. St. Mrs. Myrtle O. Naughton-25 N. Rose |   |   |  |                    |  |
| 18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)<br>PART I. DEATH WAS CAUSED BY.  |  |   |  |  |                         |  |   |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                   |                    |  |
| IMMEDIATE CAUSE (a) myocardial infarction  |  |   |  |  |                         |  |   |   |   |  |                    |  |
| 4100<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last  |  |   |  |  |                         |  |   |   |   |  |                    |  |
| DUE TO, OR AS A CONSEQUENCE OF (b) myocardial insufficiency  |  |   |  |  |                         |  |   |   |   |  |                    |  |
| DUE TO, OR AS A CONSEQUENCE OF (c)   |  |   |  |  |                         |  |   |   |   |  |                    |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |   |  |  |                         |  |   |   |   |  |                    |  |
| 19a. DATE OF OPERATION   |  |   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |                         |  |   | 20a. AUTOPSY?   |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |                    |  |
|  |  |   |  |  |                         |  |   | YES <input type="checkbox"/> NO <input type="checkbox"/>  |   | YES <input type="checkbox"/> NO <input type="checkbox"/>       |                    |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |                         | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |   |   |   |  |                    |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |                         | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |   |   |   |  |                    |  |
| 22a I certify that (I) (this hospital) attended the deceased from 1969, 19, to Dec 1980, that (I) (we) last saw the deceased alive on Dec 12, 1980, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |  |  |                         |  |   |   |   |  |                    |  |
| 22b. SIGNATURE   |  |   |  | DEGREE   |                         |  |   | 22c. DATE SIGNED  |   |  |                    |  |
| Charles C. MacMinn MD  |  |   |  | ATTENDING PHYSICIAN  |                         |  |   | MEDICAL <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF <input type="checkbox"/> PHYSICIAN <input type="checkbox"/> |   | 2/5/82   |                    |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  |   |  | 22e. ADDRESS   |                         |  |   |   |   |  |                    |  |
| CHARLES C. MACMINN   |  |   |  | 2900 E. BALTIMORE ST   |                         |  |   |   |   |  |                    |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)   |  |   |  | 23b. DATE  |                         | 23c. NAME OF CEMETERY OR CREMATORY   |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE  |   |  |                    |  |
| Entombment   |  |   |  | Feb. 8, 1982   |                         | Dulaney Valley Memorial Mausoleum  |   | Timonium, Md.   |   |  |                    |  |
| 24. FUNERAL DIRECTOR<br>NAME   |  |   |  | 24b. ADDRESS   |                         | 25. DATE REC'D. BY REGISTRAR   |   | 25b. REGISTRAR'S SIGNATURE  |   |  |                    |  |
| John St. Moran, Inc.   |  |   |  | 3000 E. Baltimore St.<br>Baltimore, Md. 21224  |                         | FEB 9 1982   |   | James J. [Signature]  |   |  |                    |  |

MEDICAL CERTIFICATION

99

0602 BP



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 7 DAYS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

|  |  |  |  |  |  |   |  |  |  |  |  |   |   |  |  |  |  |                        |  |  |
|--|--|--|--|--|--|---|--|--|--|--|--|---|---|--|--|--|--|------------------------|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  |  | FIRST<br>Nathan  |  |  | MIDDLE<br>MILNER  |  |  | LAST<br>Nelson   |  |  | 2a. DATE KNOWN OF DEATH<br>ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR         |   |  | 2b. HOUR   |  |  |                        |  |  |
| 3. SEX<br>Male   |  |  | 4. RACE<br>White   |  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>8-20-72   |  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>9 YRS.                        |  |  | IF UNDER 1 YR.<br>MONTHS DAYS HOURS MIN.  |   |  | 7c. DATE PRONOUNCED DEAD<br>MONTH DAY YEAR<br>2 9 1982 |  |  | 7d. HOUR<br>5:56 P. M. |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MARYLAND  |  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U. S. A.   |  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City, MD.      |  |  |   |   |  |  |  |  |                        |  |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore   |  |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Johns Hopkins Hospital |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>STUDENT  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY                                |  |  |   |   |  |  |  |  |                        |  |  |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |  | 13a. STATE<br>MARYLAND   |  |  | 13b. COUNTY<br>BALTIMORE  |  |  | 13c. CITY OR TOWN<br>SPARKS                                      |  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |  | 13e. STREET ADDRESS<br>15910 YORK ROAD                 |  |  |                        |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>THOMAS C. NELSON   |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>PORTIA L. SLAUGHTER   |  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br>NO   |  |  | 16b. SOCIAL SECURITY NO.<br>218-72-0808                          |  |  | 17. INFORMANT<br>THOMAS NELSON, 15910 YORK ROAD, SPARKS, MD.                                    |   |  | ADDRESS<br>21152                                       |  |  |                        |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cranio-Cerebral Trauma</u><br>8136<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last:<br>(b) _____<br>(c) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>DUE TO, OR AS A CONSEQUENCE OF   |  |  |  |  |  |   |  |  |  |  |  |   |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH           |  |  |                        |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 a.  |  |  |  |  |  |   |  |  |  |  |  |   |   |  |  |  |  |                        |  |  |
| 19a. DATE OF OPERATION   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  |  |   |  |  |  |  |  |   | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |  |                        |  |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |  |  | 21b. TIME OF INJURY<br>HOUR <input checked="" type="checkbox"/> MONTH DAY YEAR<br>4:40 P.M. 2 8 1982                                 |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)<br>subject struck by auto while riding bike                                   |  |  |  |  |  |   |   |  |  |  |  |                        |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK   |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)<br>road  |  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br>York & Corbett Rds., Baltimore, Maryland Co.   |  |  |  |  |  |   |   |  |  |  |  |                        |  |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . |  |  |  |  |  |   |  |  |  |  |  |   |   |  |  |  |  |                        |  |  |
| ACTUAL SIGNATURE<br><i>Virginia L. Dolan</i>   |  |  | TITLE (SPECIFY)<br>M.D. Assistant  |  |  | MEDICAL EXAMINER  |  |  | DATE SIGNED<br>2-10-82   |  |  |   |   |  |  |  |  |                        |  |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)<br>Virginia L. Dolan, M.D.  |  |  | ADDRESS<br>111 Penn Street   |  |  |   |  |  |  |  |  |   |   |  |  |  |  |                        |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>BURIAL   |  |  | 23b. DATE<br>2-12-82   |  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>GORSUCH CEMETERY  |  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>BALTO, GLENCE, MD. |  |  |   |   |  |  |  |  |                        |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><i>L. Hartenstein</i>  |  |  | ADDRESS<br>New Freedom, PA 17349   |  |  | 25a. DATE REC'D. BY REGISTRAR<br>FEB 16 1982  |  |  | 25b. REGISTRAR'S SIGNATURE<br><i>Thomas J. North</i>             |  |  |   |   |  |  |  |  |                        |  |  |

RECEIVED  
JAN 11 1964  
BIRMINGHAM

TO THE DIRECTOR  
FEDERAL BUREAU OF INVESTIGATION  
WASHINGTON, D. C. 20535

FROM THE DIRECTOR  
BIRMINGHAM OFFICE

SUBJECT: [Illegible]

RE: [Illegible]

[Illegible text follows, appearing to be a memorandum or report body.]

FOR  
1. STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 4 0 6 0

REG. NO.

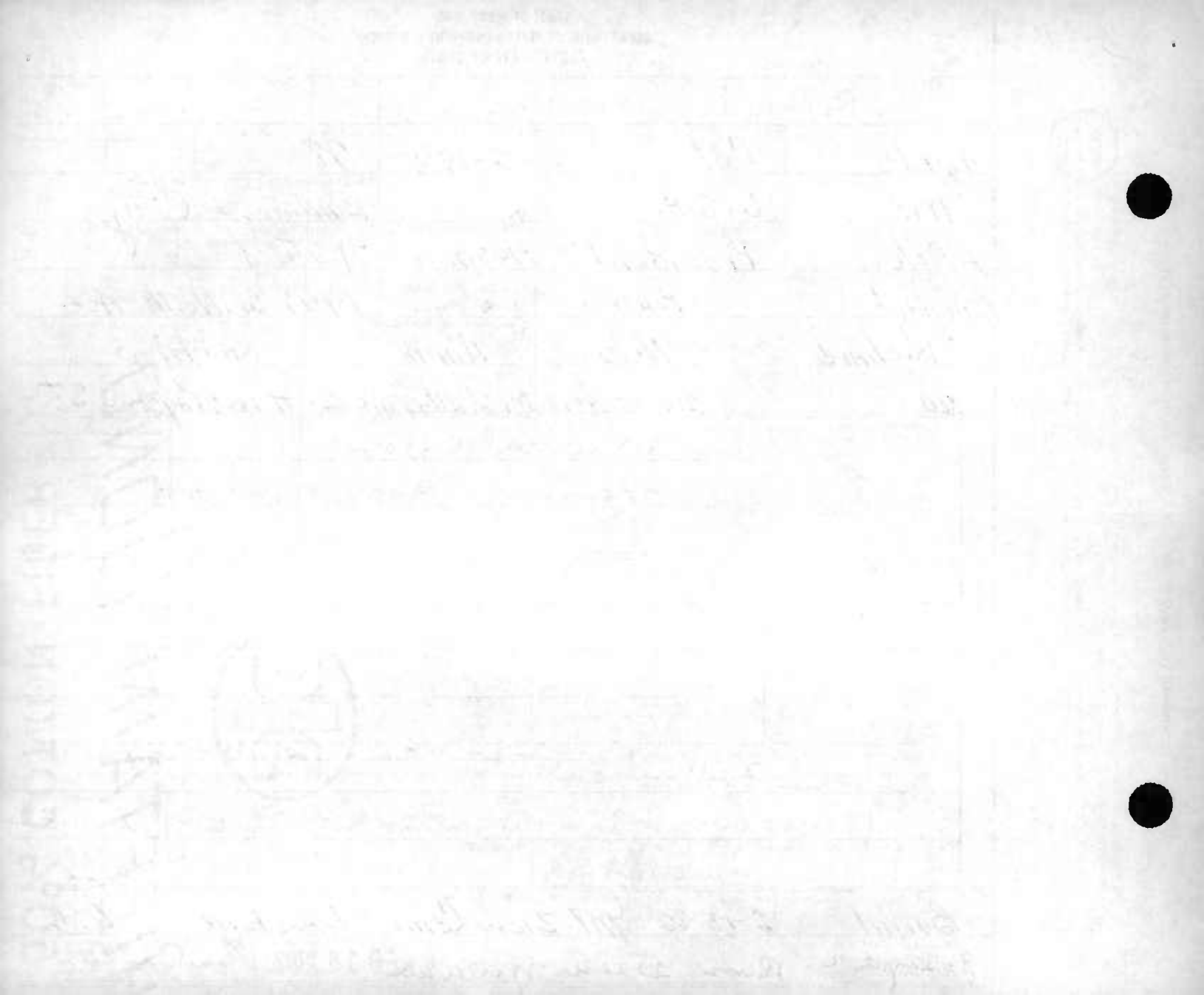
|  |  |  |  |   |   |   |   |
|--|--|--|--|---|---|---|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>Richard Nelson   |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>2-11-82 |   |   | 2b. HOUR<br>5:40 AM   |   |
| 3. SEX<br>male   |  | 4. RACE<br>Col   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>2-2-1904  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>78 YRS   |   |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br>Md.  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.                                      |   |
| 10. CITY OR TOWN OF DEATH<br>BALTO.  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Provident Hosp. |  |   |   | 12. USUAL OCCUPATION<br>(FULL-TIME OR MOST OF WORKING LIFE)<br>Retired                          |   |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>Maryland   |  | 13b. COUNTY  |  | 13c. CITY OR TOWN<br>BALTO.   |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Richard Nelson   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Anna Rawlings   |  | 16. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>NO   |   |   |   |
| 16b. SOCIAL SECURITY NO.<br>216-05-0886A   |  | 17. INFORMANT<br>ADDRESS<br>Mrs. Catherine Scott 1807 Payson St  |  |   |   |   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) 3109<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) Organic Brain Syndrome<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)  |  |  |  |   |   |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |  |  |   |   |   |   |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |   |   |   |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |   |   |
| 22a. I certify that (I) (this hospital) attended the deceased from 1-29-1982 to 2-11-1982, that (I) (we) last saw the deceased alive on 2-11-1982 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |  |  |  |   |   |   |   |
| 22b. SIGNATURE<br>H Swadoss  |  |  |  | DEGREE<br>M.D. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>   |   | 22c. DATE SIGNED<br>2-11-82   |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>H. D. Swadoss   |  |  |  | 22e. ADDRESS<br>Provident Hosp.   |   |   |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial   |  | 23b. DATE<br>2-13-82   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Mt. Zion Cem.   |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Nanshewe Md.                                      |   |
| 24. FUNERAL DIRECTOR<br>NAME<br>Joseph L. Run  |  |  |  | ADDRESS<br>2222 W North Ave   |   | 25a. DATE REC'D. BY REGISTRAR<br>FEB 16 1982  |   |
|  |  |  |  | REGISTRAR'S SIGNATURE<br>Thane Jan Mathen   |   |   |   |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Possession of this certificate should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the local health officer.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrars, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the registrar after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1- FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 4 0 6 1

REG. NO.

|  |  |   |   |   |   |  |
|--|--|---|---|---|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Estella I NEUBERGER</b>  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>February 23, 1982</b> |   | 2b. HOUR<br><b>7:58<sup>a</sup></b>                             |  |
| 3. SEX<br><b>Female</b>  |  | 4. RACE<br><b>White</b>   |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>April 27, 1898</b>   |   |  |
| 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>83</b>   |  | 7. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   |  |
| 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b>  |  | 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   |   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Maryland General Hospital</b>               |   |  |
| 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Housewife</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY   |   | 13a. STREET ADDRESS<br><b>12833 Dover Road</b>  |   |  |
| 13b. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 13c. CITY OR TOWN<br><b>Reisterstown</b>  |   | 13d. STATE<br><b>Md.</b>  |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Benjamin Forwood</b>  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Bertha Justice</b>  |   | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>No</b>   |   |  |
| 16b. SOCIAL SECURITY NO.<br><b>215-48-5615</b>   |  | 17. INFORMANT<br><b>Mrs. Catherine Loretta Gent</b>   |   | 17. ADDRESS<br><b>Reisterstown, Md.</b>   |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br><b>THROMBOCYTOPENIA WITH HEMMORRHAGE</b><br>IMMEDIATE CAUSE (a) <b>2875</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) _____<br>DUE TO, OR AS A CONSEQUENCE OF (c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |   |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>10 YEARS</b> |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a):  |  |   |   |   |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |   |  |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   |  |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)   |  | 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   |  |
| 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  | 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>February 10, 1982</b> , to <b>February 23, 1982</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>February 23, 1982</b> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) (not) view the body after death. |   | 22b. SIGNATURE<br><b>Joseph Ganey, M.D.</b>   |   |  |
| 22c. DATE SIGNED<br><b>2/23/82</b>   |  | 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Joseph Ganey, M.D.</b>  |   | 22e. ADDRESS<br><b>c/o Maryland General Hospital</b>  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br><b>Burial</b>   |  | 23b. DATE<br><b>Feb. 26, 82</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Grace Cemetery</b>   |   |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Chesnutridge, Reisterstown</b>  |  | 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Eline Funeral Home Reisterstown, Md. 21136</b>   |   | 25a. DATE REC'D. BY REGISTRAR<br><b>FEB 25 1982</b>   |   |  |
| 25b. REGISTRAR'S SIGNATURE<br><b>Theresa J. [Signature]</b>  |  | 25c. REGISTRAR'S NAME<br><b>Theresa J. [Signature]</b>  |   | 25d. REGISTRAR'S ADDRESS<br><b>Reisterstown, Md.</b>  |   |  |





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  |  |  |  |   |  |  |
|---|--|--|--|--|--|--|---|--|--|
| 1. FOR STATE REGISTRAR  |  |  |  |  | REG. NO.   |  |   |  |  |
| 1. DECEASED NAME (TYPE OR PRINT) <b>LEWIS E. NEWCOMER</b>   |  |  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR <b>FEBRUARY 14, 1982</b> 2b. HOUR <b>10:30A</b>             |  |   |  |  |
| 3. SEX <b>Male</b>  |  | 4. RACE <b>White</b>   |  | 5. DATE OF BIRTH MONTH DAY YEAR <b>Dec. 14, 1907</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY) <b>74 yrs</b> YRS                  |   | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN. |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Virginia</b>   |  | 7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.     |   |  |  |
| 11. CITY OR TOWN OF DEATH <b>Baltimore</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Church Home &amp; Hospital</b> |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Retired</b>                 |  |   | 12b. KIND OF BUSINESS OR INDUSTRY <b>- -</b>           |  |
| 13a. STATE <b>Maryland</b> 13b. COUNTY <b>- -</b> 13c. CITY OR TOWN <b>Baltimore</b>  |  |  |  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS <b>2027 Madison Street</b>  |  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST <b>Samuel Newcomer</b>  |  |  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Annie Gaylor</b>                               |  |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>   |  | 16b. SOCIAL SECURITY NO. <b>705-07-6409</b>  |  | 17. INFORMANT ADDRESS <b>Mr. Clarence Newcomer-3344 Keswick Road</b>   |  |  |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: <b>ESOPHAGEAL CARCINOMA</b>   |  |  |  |  |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| IMMEDIATE CAUSE (a) <b>1509</b>   |  |  |  |  |  |  |   |  |  |
| DUE TO, OR AS A CONSEQUENCE OF (b)  |  |  |  |  |  |  |   |  |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.  |  |  |  |  |  |  |   |  |  |
| DUE TO, OR AS A CONSEQUENCE OF (c)  |  |  |  |  |  |  |   |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |  |  |  |  |  |   |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |   |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |  |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>FEBRUARY 11, 1982</b> to <b>FEBRUARY 14, 1982</b> , that (I) (we) last saw the deceased alive on <b>FEBRUARY 14, 1982</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (they) did not view the body after death. |  |  |  |  |  |  |   |  |  |
| 22b. SIGNATURE <i>Peter A. Holt</i> DEGREE  |  |  |  |  | 22c. ADDRESS <b>CHURCH HOSPITAL CORPORATION, 100 N. BROADWAY, BALTIMORE, MARYLAND 21231</b>  |  |   |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>PETER A. HOLT, M.D.</b>  |  |  |  |  | 22e. ADDRESS <b>CHURCH HOSPITAL CORPORATION, 100 N. BROADWAY, BALTIMORE, MARYLAND 21231</b>  |  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>   |  | 23b. DATE <b>2/17/82</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY <b>St. Marys Cem (Hampden)</b>  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore, Maryland</b> |   |  |  |
| 24. FUNERAL DIRECTOR NAME <b>A. Alan Seitz</b> <b>Funeral Home 3818 Roland Ave.</b>   |  |  |  |  | 25a. RECEIVED BY REGISTRAR 25b. REGISTRAR'S SIGNATURE <i>[Signature]</i> <b>FEB 17 1982</b>  |  |   |  |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR  
1. STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |   |   |  |  |   |
|--|---|---|--|--|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Booker Nichols</b>   |   |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>February 20, 1982</b>          |  | 2b. HOUR<br><b>8:50A M</b>                                      |
| 3. SEX<br><b>Male</b>  | 4. RACE<br><b>Black</b>   | 5. DATE OF BIRTH<br><b>11<sup>TH</sup> 18 05</b>  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>76</b><br>YRS.                     |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>S.C.</b>   | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.        |  |   |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Maryland General Hospital</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)         |  | 12b. KIND OF BUSINESS OR INDUSTRY                               |
| 13a. STATE<br><b>MD</b>  |   | 13b. COUNTY<br><b>Baltimore</b>   | 13c. CITY OR TOWN<br><b>Baltimore</b>                                    | 13e. STREET ADDRESS<br><b>2563 Seamon Avenue</b>                                     |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Benjamin Nicholas</b>   |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Flora Stackhouse</b> |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>No</b>  |   | 16b. SOCIAL SECURITY NO.<br><b>249-24-2734</b>  | 17. INFORMANT ADDRESS<br><b>Marie Weeks 2563 Seamon Avenue</b>           |  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardio Respiratory Arrest</b><br><b>4360</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>Multiple Cerebrovascular Accidents</b><br>DUE TO, OR AS A CONSEQUENCE OF (c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>5 Months</b> |   |   |  |  |   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |   |   |  |  |   |
| 19a. DATE OF OPERATION<br><b>9/2/81</b><br><b>10/6/81</b>  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>Gluteal Flap - Decubitus Repair Flap. Diverting Colostomy</b>  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |
| 20b. IF YES, WERE FINDINGS USED IN IDENTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |   | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)    |  |  |   |
| 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>19</b>   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |  |  |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>August 26, 1981</b> to <b>February 20, 1982</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>February 20, 1982</b> and that in (my/our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) did <input checked="" type="checkbox"/> did not view the body after death.                       |   |   |  |  |   |
| 22b. SIGNATURE<br><b>ROBERT CZAKO, M.D.</b>  |   | DEGREE<br><b>MD</b>   |  | 22c. DATE SIGNED<br><b>2/20/82</b>   |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>ROBERT CZAKO, M.D.</b>   |   | 22e. ADDRESS<br><b>c/o Maryland General Hospital</b>  |  |  |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |   | 23b. DATE<br><b>2/25/82</b>   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Cedar Hill Cem.</b>             |  | 23d. LOCATION<br>CITY COUNTY STATE<br><b>Baltimore Co. Md.</b>  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Wm. C. March F/H</b>  |   |   | 25a. DATE REC'D. BY REGISTRAR<br><b>FEB 22 1982</b>                      |  | 25b. REGISTRAR'S SIGNATURE<br><i>James J. [Signature]</i>       |

UNITED STATES  
DEPARTMENT OF JUSTICE  
FEDERAL BUREAU OF INVESTIGATION

February 20, 1962

Chicago

Director

Baltimore City

Maryland General Hospital

Baltimore

Cardio Respiratory Arrest

Multiple Cardiovascular Accidents

Medical Director  
Baltimore City  
Department of Health

February 20, 1962

cc: Director

cc: Maryland General Hospital

*John J. [Signature]*  
John J. [Signature]  
John J. [Signature]

SEE PAGE 2

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Patient must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  | REG. NO. 82 04064   |  |  |  |
|--|--|--|--|---|--|--|--|
| 1. FOR<br>STATE<br>REGISTRAR   |  |  |  |   |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <i>Emma C. Nines</i>   |  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR <i>2-1-82</i>   |  | 2b. HOUR<br><i>4:30 A M</i>  |  |
| 3. SEX<br><i>Female</i>  |  | 4. RACE<br><i>Caucasian</i>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR <i>12 22 21</i>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><i>60</i> YRS.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><i>MD</i>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><i>USA</i>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><i>Baltimore City MD</i>   |  |
| 10. CITY OR TOWN OF DEATH<br><i>Baltimore</i>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><i>University of Maryland Hosp.</i> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><i>Deelder</i>  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><i>Printing Shop</i>  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE <i>MD</i> 13b. COUNTY <i>-</i>  |  |  |  | 13c. CITY OR TOWN<br><i>Baltimore</i>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST <i>John Greenwood</i>   |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST <i>Elise Foreman</i>  |  |  |  |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <i>NO</i>  |  |  |  | 17. SOCIAL SECURITY NO. <i>218-16-1737</i> 18. INFORMANT <i>Harrell Nines</i> ADDRESS <i>1221 Hollins St. Baltimore MD 21223</i>                            |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>cardiopulmonary arrest</i><br>DUE TO, OR AS A CONSEQUENCE OF (b) <i>liver and kidney failure</i><br>DUE TO, OR AS A CONSEQUENCE OF (c) <i>alcoholic liver disease</i>   |  |  |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <i>peritonitis</i>  |  |  |  |   |  |  |  |
| 19a. DATE OF OPERATION<br><i>None</i>  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. <i>-</i> 19 <i>82</i>  |  | 21c. HOW INJURY OCCURRED<br>(ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)<br><i>-</i>   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)<br><i>-</i>   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br><i>-</i>   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>1-24</i> , 19 <i>82</i> , to <i>2-1</i> , 19 <i>82</i> , that (I) (we) test<br>saw the deceased alive on <i>2-1</i> , 19 <i>82</i> , and that in (my (our)) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) did (did not) view the body after death. |  |  |  |   |  |  |  |
| 22b. SIGNATURE<br><i>Linda A Headrick MD</i>   |  |  |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>        |  | 22c. DATE SIGNED<br><i>2-1-82</i>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><i>Linda A Headrick MD</i>  |  |  |  | 22e. ADDRESS<br><i>22 S. Green St Baltimore</i>   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><i>burial</i>  |  | 23b. DATE<br><i>2-4-1982</i>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><i>Green Hill Cem.</i>  |  | 23d. LOCATION<br>(CITY OR TOWN) COUNTY STATE<br><i>Baltimore City MD</i>   |  |
| 24. FUNERAL DIRECTOR<br>NAME <i>Emma v. Lee Inc.</i> ADDRESS <i>901 Hollins St. Baltimore MD 21223</i>   |  |  |  | 25. DATE RECEIVED BY REGISTRAR<br><i>FEB 6 1982</i>   |  |  |  |
| 26. REGISTRAR'S SIGNATURE<br><i>James J. ...</i>   |  |  |  |   |  |  |  |

(12)

NOTED  
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U.S. DEPT. OF AGRICULTURE  
BUREAU OF PLANT INDUSTRY  
WASHINGTON, D. C.

(12)



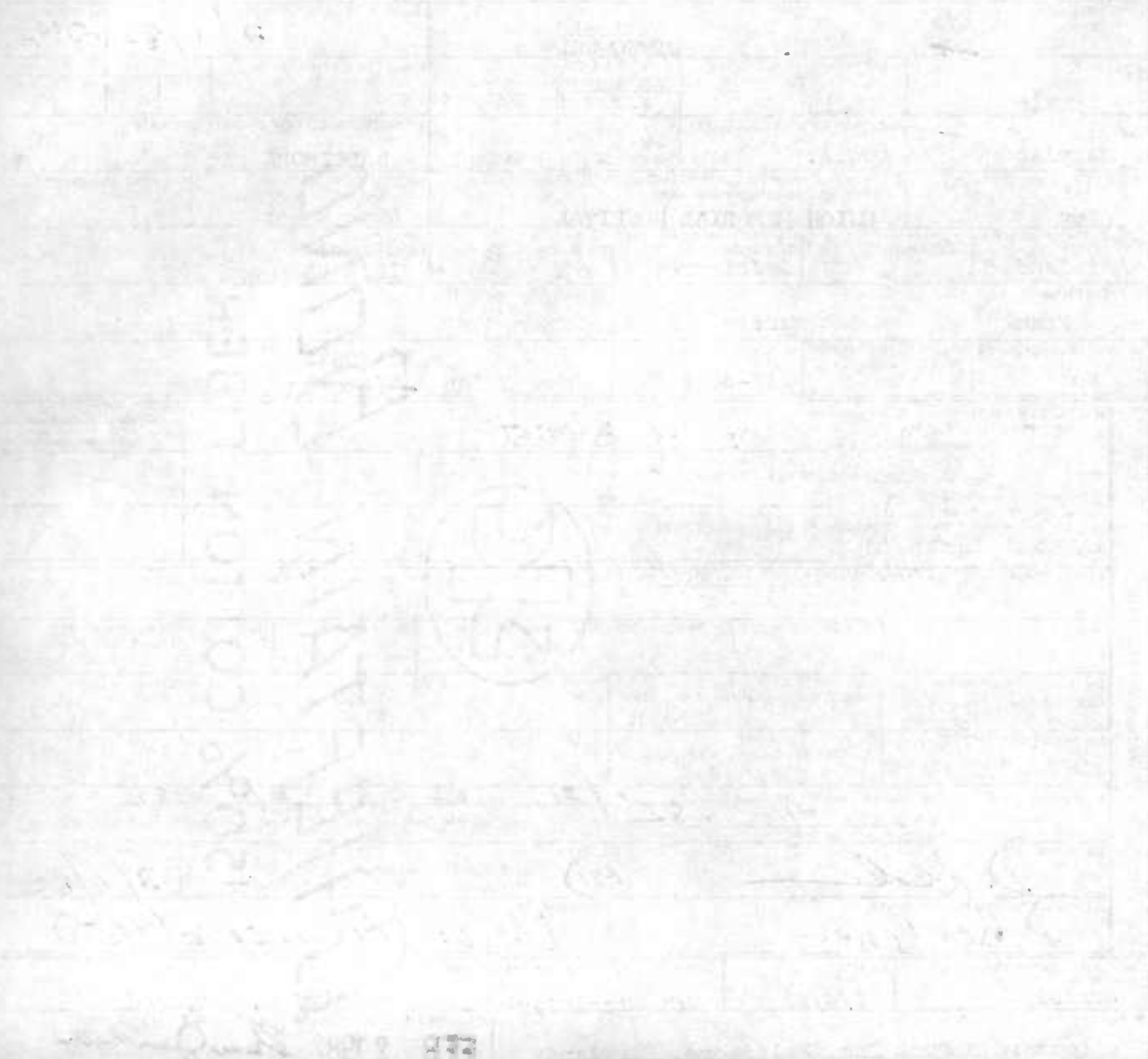
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at 1-800-338-3300.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  | REG. NO. 8204065  |  |   |  |
|---|--|--|--|---|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) <b>Eva Nitkoski</b>  |  |  |  | 2a. DATE OF DEATH MONTH <b>2</b> DAY <b>1</b> YEAR <b>1982</b> 2b. HOUR <b>2:10 A.M.</b>  |  |   |  |
| 3. SEX <b>Female</b>  |  | 4. RACE <b>White</b>   |  | 5. DATE OF BIRTH <b>2/6/94</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY) <b>87</b>   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>   |  | 7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE City</b> MD.  |  |
| 10. CITY OR TOWN OF DEATH <b>CITY</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>UNION MEMORIAL HOSPITAL</b>            |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Home Maker</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| 13a. STATE <b>Maryland</b>  |  |  |  | 13b. COUNTY <b>Baltimore</b>  |  | 13c. CITY OR TOWN <b>Baltimore</b>  |  |
| 14. FATHER'S NAME FIRST <b>Frank</b> MIDDLE <b>Hartka</b> LAST <b>Hartka</b>  |  |  |  | 15. MOTHER'S MAIDEN NAME FIRST <b>Anna</b> MIDDLE <b>Wisniewska</b> LAST <b>Wisniewska</b>  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>   |  | 16b. SOCIAL SECURITY NO. <b>217-48-2088</b>  |  | 17. INFORMANT <b>Nitkoski</b> ADDRESS <b>Miss Helen A. Nitkoski</b> Same  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br><b>1749</b> IMMEDIATE CAUSE (a) <b>ca of Breast</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO, OR AS A CONSEQUENCE OF (c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>6 months</b> |  |  |  |   |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____   |  |  |  |   |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>2/1/82</b> to <b>2/1/82</b> that (I) (we) lost saw the deceased alive on <b>2/1/82</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) (did) (did not) view the body after death.   |  |  |  |   |  |   |  |
| 22b. SIGNATURE <b>D. Berlinc</b>  |  | DEGREE <b>MD</b> ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED <b>2/1/82</b>  |  |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>D. Berlinc</b>   |  | 22e. ADDRESS <b>Union Memorial (Hosp)</b>  |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>   |  | 23b. DATE <b>2/4/82</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY <b>St Stanislaus</b>   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore, Maryland</b>  |  |
| 24. FUNERAL DIRECTOR NAME <b>Leonard J Ruck Inc. Baltimore, Maryland</b> ADDRESS  |  |  |  | 25a. DATE REC'D. BY REGISTRAR <b>FEB 2 1982</b> REGISTRAR'S SIGNATURE <b>Shane Jan Nester</b>   |  |   |  |

MEDICAL CERTIFICATION



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS ANTICIPATED, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE REGISTRAR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PM 3. RETAIN PAGE 5 IN YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A15 ME (1))  
15M 2/80

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |                         |  |   |   |  |  |  |  |  | REG. NO. 5 2 0 4 0 6 6                       |  |
|--|-------------------------|--|---|---|--|--|--|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Norman Lee Nodine Sr.</b>   |                         |  |   |   |  | 2a. DATE KNOWN OF DEATH<br>ESTIMATED <input checked="" type="checkbox"/> MONTH <input type="checkbox"/> DAY <input type="checkbox"/> YEAR <b>2 16 82</b> |  | 7b. HOUR <b>M</b>  |  |  |  |
| 3. SEX<br><b>male</b>  | 4. RACE<br><b>white</b> | 5. DATE OF BIRTH<br>MONTH <b>July</b> DAY <b>15</b> YEAR <b>28</b>   | 6. AGE (IN YEARS)<br>LAST BIRTHDAY <b>53</b> YRS. | IF UNDER 1 YR.<br>MONTHS <b></b> DAYS <b></b>   | IF UNDER 24 HRS.<br>HOURS <b></b> MIN. <b></b> | 2c. DATE PRONOUNCED DEAD<br>MONTH <b>2</b> DAY <b>16</b> YEAR <b>19 82</b>   |  | 7d. HOUR <b>12:23</b>  |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   |                         | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b>  |  | AM MD.   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |                         | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>SouthBaltimoreGeneralHospital</b> |   |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Fork-Lift Oper.</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Continental Can Co.</b>                        |  |  |  |
| 13a. STATE <b>Maryland</b> 13b. COUNTY <b>Anne Arundel</b> 13c. CITY OR TOWN <b>Pasadena</b>   |                         |  |   |   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 13e. STREET ADDRESS<br><b>8368 Hilda Rd.</b>   |  |  |  |
| 14. FATHER'S NAME<br>FIRST <b>Earl</b> MIDDLE <b>Allen</b> LAST <b>Nodine</b>  |                         |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>Levisa</b> MIDDLE <b></b> LAST <b>Holmes</b>   |  |  |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN) <b>No</b>  |                         | 16b. SOCIAL SECURITY NO.<br><b>N/A</b>   |   | 17. INFORMANT (Wife)<br><b>Mrs. Camilla M. Nodine, Linthicum</b>  |  | ADDRESS <b>557 Shipley Rd.</b>   |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Arteriosclerotic cardiovascular disease</b><br><b>4292</b><br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b) <b></b><br>(c) <b></b>   |                         |  |   |   |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).  |                         |  |   |   |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION   |                         |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  |  |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>    |  |  |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |                         |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)  |  |  |  |  |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |                         |  |   | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |  |  |  |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |                         |  |   |   |  |  |  |  |  |  |  |
| ACTUAL SIGNATURE <b>H.R. Guard</b>   |                         |  |   | M.D. <b>Assistant</b>   |  |  |  | DATE SIGNED <b>2/16/82</b>   |  |  |  |
| EXAMINER'S NAME (TYPE OR PRINT) <b>Hormez R. Guard, M.D.</b>   |                         |  |   | ADDRESS <b>111 Penn Street, Balto, MD 21201</b>   |  |  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |                         | 23b. DATE<br><b>19 Feb. 82</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Dulaney Valley Mem.</b>  |  |  |  | 23d. LOCATION<br>CITY OR TOWN <b>Cockeysville</b> COUNTY <b>Balt.</b> STATE <b>MD.</b> |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME <b>Singleton Funeral Home</b> ADDRESS <b>Glen Burnie, MD.</b>   |                         |  |   | 25a. DATE REC'D. BY REGISTRAR<br><b>FEB 18 1982</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><i>Thomas J. Martin</i>  |  |  |  |  |  |

NOV 10 1900

Wm. H. H. H.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified. (See page 1)

Item 4 per phone 2/10/82 dad

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

820406

REG. NO.

|   |  |  |        |  |  |  |                         |
|---|--|--|--------|--|--|--|-------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>ANNA</b>   |  | FIRST <b>May</b>   | MIDDLE | LAST <b>NOEL</b>   | 2a. DATE OF DEATH MONTH <b>2</b> DAY <b>5</b> YEAR <b>82</b> |  | 2b. HOUR <b>11:35</b> M |
| 3 SEX <b>F</b>  | 4. RACE <b>Caucasian</b>   | 5. DATE OF BIRTH MONTH <b>6</b> DAY <b>10</b> YEAR <b>26</b>   |        | 6. AGE (IN YEARS LAST BIRTHDAY) <b>55</b> YRS  |  | IF UNDER 1 YEAR MONTHS <b>6</b> DAYS <b>14</b> IF UNDER 22 YRS. HOURS MIN.   |                         |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>USA</b>  | 7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |        | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b> MD.                               |  |  |                         |
| 10. CITY OR TOWN OF DEATH <b>BALTO.</b>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>SINAI Hospital</b> |  |        | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Supervisor</b>              |  | 12b. KIND OF BUSINESS OR INDUSTRY <b>Commercial</b>  |                         |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>md</b> 13b. CITY OR TOWN <b>Worcester</b> 13c. CITY OR TOWN <b>OCEAN CITY</b>  |  |  |        | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS <b>13313 CONSTITUTIONAL AVE</b>  |                         |
| 14. FATHER'S NAME FIRST <b>August Rohlfing</b> MIDDLE LAST  |  |  |        | 15. MOTHER'S MAIDEN NAME FIRST <b>Kathleen Finney</b> MIDDLE LAST                            |  |  |                         |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? <b>No</b> (IF YES, GIVE WAR OR DATES)  |  | 16b. SOCIAL SECURITY NO. <b>220-14-9544</b>  |        | 17. INFORMANT <b>Joseph H. Noel - 13313 Constitutional Ave. Ocean City, MD. - 21842</b>      |  |  |                         |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>LUNG CAUSE TOTAL body METS</b><br><b>1629</b><br>DUE TO, OR AS A CONSEQUENCE OF (b)<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF (c) |  |  |        |  |  |  |                         |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)   |  |  |        |  |  |  |                         |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |        | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                         |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>  |        | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)               |  |  |                         |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |        | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |  |                         |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>1/13</b> 19 <b>82</b> to <b>2/15</b> 19 <b>82</b> , that (I) (we) last saw the deceased alive on <b>2/15</b> 19 <b>82</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.        |  |  |        |  |  |  |                         |
| 22b. SIGNATURE <b>John Gordon</b> DEGREE <b>MD</b>  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>    |        |  |  | 22c. DATE SIGNED <b>2/15/82</b>  |                         |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>JOHN GORDON</b>  |  | 22e. ADDRESS <b>SINAI</b>  |        |  |  |  |                         |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>   |  | 23b. DATE <b>2-9-82</b>  |        | 23c. NAME OF CEMETERY OR CREMATORY <b>Moreland Memorial Park</b>                             |  | 23d. LOCATION CITY OR TOWN <b>BALTO, MD.</b> COUNTY STATE  |                         |
| 24. FUNERAL DIRECTOR <b>John C. Miller Inc-6415 Belair Rd.</b>  |  |  |        | 25a. DATE REC'D. BY REGISTRAR <b>FEB 8 1982</b>  |  | 25b. REGISTRAR'S SIGNATURE <b>James J. [Signature]</b>   |                         |

BP

|              |                  |              |
|--------------|------------------|--------------|
| 1. Name      | 2. Address       | 3. City      |
| 4. State     | 5. Zip           | 6. Phone     |
| 7. Email     | 8. Date          | 9. Signature |
| 10. Title    | 11. Organization | 12. Contact  |
| 13. Notes    | 14. Remarks      | 15. Comments |
| 16. Status   | 17. Action       | 18. Date     |
| 19. Initials | 20. Signature    | 21. Date     |
| 22. Remarks  | 23. Signature    | 24. Date     |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

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1- FOR STATE REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 4 0 6 8

REG. NO.

|  |  |   |  |  |                            |  |
|--|--|---|--|--|----------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><i>IDA Unela NORBERG</i>   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><i>02, 10 '82</i> |  | 2b. HOUR<br><i>6:40 AM</i> |  |
| 3. SEX<br><i>Female</i>  |  | 4. RACE<br><i>White</i>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><i>07-18-10</i>  |                            |  |
| 6. AGE (IN YEARS LAST BIRTHDAY)<br><i>71</i> YRS.  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><i>Baltimore</i> MD.   |                            |  |
| 10. CITY OR TOWN OF DEATH<br><i>Baltimore</i>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><i>ST AGNES HOSPITAL</i>                       |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><i>Homemaker</i>                           |                            |  |
| 13a. STATE<br><i>Md.</i>   |  | 13b. COUNTY<br><i>Anne Arundel</i>  |  | 13c. CITY OR TOWN<br><i>Pasadena</i>   |                            |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><i>William F. Gadd</i>   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><i>Bs Barbara Ruman</i>  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, AND OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><i>No</i> |                            |  |
| 16b. SOCIAL SECURITY NO.<br><i>215-07-0357</i>   |  | 17. INFORMANT<br><i>Sister</i> ADDRESS <i>21230 Ethel Wheeler 1619 Clarkson St. Balto. Md.</i>  |  |  |                            |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Cardiopulmonary arrest</i><br>1539<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <i>Carcinoma of colon - metastatic</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |   |  |  |                            |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) _____   |  |   |  |  |                            |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                      |                            |  |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)    |  |  |                            |  |
| 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><i>P.M. 19</i>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |  |  |                            |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |                            |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>1/13/82</i> 19 <i>82</i> to <i>2/10</i> 19 <i>82</i> , that (I) (we) lost saw the deceased alive on <i>2/10</i> 19 <i>82</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (we) (did) (not) view the body after death.  |  |   |  |  |                            |  |
| 22b. SIGNATURE<br><i>Lin, Sow-Sei</i>  |  |   |  | 22c. DATE SIGNED<br><i>2/10/82</i>   |                            |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><i>LIN, SOW-SEI</i>   |  |   |  | 22e. ADDRESS<br><i>900 S. Caton Ave., Balto Md 21229</i>   |                            |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><i>Burial</i>   |  | 23b. DATE<br><i>2/13/1982</i>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><i>Glen Haven Mem. Park</i>  |                            |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><i>Glen Burnie Anne Arundel Md.</i>  |  | 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><i>Mc Cully F. H. Mountain &amp; Tice Pasadena, Md. 21222</i>   |  |  |                            |  |
| 25a. DATE REC'D. BY REGISTRAR  |  | 25b. REGISTRAR'S SIGNATURE<br><i>Thomas J. [Signature]</i>  |  |  |                            |  |

FEB 16 1982





RECEIVED FEB 16 1965  
U.S. DEPARTMENT OF AGRICULTURE  
WASHINGTON, D.C. 20250

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 4 0 6 9

1- FOR STATE REGISTRAR **Michael Norr Jr.**

REG. NO.

|   |  |   |   |  |  |  |  |   |  |
|---|--|---|---|--|--|--|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Michael J. Norr Jr.</b>  |  |   | 2a. DATE OF DEATH<br>MONTH <b>2</b> DAY <b>13</b> YEAR <b>82</b>          |  |  | 2b. HOUR<br><b>12:55</b> P.M.  |  |   |  |
| 3. SEX<br><b>Male</b>   |  | 4. RACE<br><b>White</b>   |   | 5. DATE OF BIRTH<br>MONTH <b>4</b> DAY <b>08</b> YEAR <b>29</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>52</b> YRS.  |  | IF UNDER 1 YEAR<br>MONTHS <b>0</b> DAYS <b>0</b> HOURS <b>0</b> MIN.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MD.</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>City</b> MD.  |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>BAL TO.</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>NORTH CHAS GEN. Hosp.</b> |   |  |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Disabled.</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| 13a. STATE<br><b>MD.</b>  |  | 13b. COUNTY<br><b>Baltimore</b>   |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 13e. STREET ADDRESS<br><b>4211 LaSalle Ave.</b>  |  |   |  |
| 14. FATHER'S NAME<br>FIRST <b>Michael</b> MIDDLE <b>L</b> LAST <b>NORR</b> SR.  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>MARY</b> MIDDLE <b>Wiessner</b> LAST |  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>no</b>   |  |   |  |
| 16b. SOCIAL SECURITY NO.<br><b>213 266829</b>   |  |   | 17. INFORMANT<br><b>Mr. Michael C. Donohue 217 S. Eaton</b>               |  |  | 18. CAUSE OF DEATH (Enter only one cause per line (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Early acute bronchopneumonia</b><br><b>7140</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>Long standing rheum. art.</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>Long standing rheum. art.</b>                          |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)                   |  |   |   |  |  |  |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   |  |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER) |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)  |  |  |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  | 22a. I certify that (I) (this hospital) attended the deceased from <b>12-23</b> , 19 <b>81</b> , to <b>2-13</b> , 19 <b>82</b> , that (I) (we) lost saw the deceased alive on <b>2-13-82</b> and that (a) (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death. |  |   |  |
| 22b. SIGNATURE<br><b>Edward Scherrer</b>  |  | 22c. DATE SIGNED  |   |  |  | 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Edward Scherrer</b>  |  |   |  |
| 22e. ADDRESS  |  | 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY) <b>Burial</b>  |   | 23b. DATE<br><b>Feb. 17, 1982</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Most Holy Redeemer</b>  |  | 23d. LOCATION<br>CITY OR TOWN <b>Baltimore</b> COUNTY <b>MD.</b> STATE  |  |
| 24. FUNERAL DIRECTOR<br>NAME <b>Leonard J. Ruck Inc.</b> ADDRESS <b>Baltimore, Maryland</b>   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>FEB 16 1982</b>   |   | 25b. REGISTRAR'S SIGNATURE<br><b>James J. [Signature]</b>  |  |  |  |   |  |

1937

Item #7a Film G565 3/18/82 rc

STATE OF MARYLAND

FOR  
1- STATE  
REGISTRARadded info g566 4/27/82 DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 4 0 7 0

REG. NO.

|  |   |  |   |  |  |   |  |
|--|---|--|---|--|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <i>Walter J. Norris Jr.</i>                |   |  | 2a. DATE OF DEATH MONTH DAY YEAR <i>2/22/82</i> |  |  | 2b. HOUR <i>4:45</i> P.M.                               |  |
| 3. SEX <i>male</i>   | 4. RACE <i>Black</i>  | 5. DATE OF BIRTH MONTH DAY YEAR <i>8/27/15</i>   |   | 6. AGE (IN YEARS LAST BIRTHDAY) <i>66</i> YRS.   |  | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN) <i>Union South Car.</i>                      | 7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>   | 8. <i>SEP.</i> MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH <i>Baltimore City</i> MD.                               |  |   |  |
| 10. CITY OR TOWN OF DEATH <i>Baltimore</i>                                     | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Duroland Nursing Home</i> |  |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Chef Cook</i>               |  | 12b. KIND OF BUSINESS OR INDUSTRY <i>Hospital</i>       |  |
| 13a. STATE <i>MD</i> 13b. COUNTY <i>VISA Ho</i> 13c. CITY OR TOWN <i>BALTO</i> |   |  |   | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS <i>Yataruba Rd.</i>                 |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST <i>Walter J. Norris Jr.</i>                |   | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Ellen F. Pearle Hunter</i>   |   |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)              |   | 16b. SOCIAL SECURITY NO. <i>247-07-9339</i>  |   | 17. INFORMANT ADDRESS <i>Hunter Norris 3425 Yataruba Rd.</i>                                 |  |   |  |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY:IMMEDIATE CAUSE (a) *Cardiac Arrest*

DUE TO, OR AS A CONSEQUENCE OF

(b) *Ventricular fibrillation*

DUE TO, OR AS A CONSEQUENCE OF

(c) *Aspiration*APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATHPART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) *Diabetes Mellitus*

|  |  |   |  |  |  |   |  |
|--|--|---|--|--|--|---|--|
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                    |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19                |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>2/17</i> 19 <i>82</i> to <i>2/22</i> 19 <i>82</i> , that (I) (we) lost saw the deceased alive on <i>2/22</i> 19 <i>82</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |  |  |  |   |  |
| 22b. SIGNATURE <i>mp / Channer</i> DEGREE  |  |   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED <i>2/22/82</i>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Moges Gebremariam</i>   |  |   |  | 22e. ADDRESS   |  |   |  |

|   |                          |  |   |
|---|--------------------------|--|---|
| 23a. BURIAL, CREMATION, REMOVAL (SPEC) <i>Burial</i>                              | 23b. DATE <i>2/25/82</i> | 23c. NAME OF CEMETERY OR CREMATORY <i>King mem PK</i>                                      | 23d. LOCATION CITY OR TOWN COUNTY STATE <i>Balto Md</i> |
| 24. FUNERAL DIRECTOR NAME <i>Lee O. Dyer F.H.</i> ADDRESS <i>4600 Liberty Ht.</i> |                          | 25a. DATE REC'D. BY REGISTRAR <i>FEB 23 1982</i> 25b. REGISTRAR'S SIGNATURE <i>Channer</i> |   |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in the office of the death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  |  |   |   |                                       |  |   |
|---|--|---|--|--|---|---|---------------------------------------|--|---|
| 1- FOR<br>STATE<br>REGISTRAR  |  | 8 2 0 4 0 7 1<br>REG. NO.   |  |  |   |   |                                       |  |   |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>ELEANOR Elizabeth NORTON</b>  |  |   |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>2 8 82</b>                  |   |                                       | 2b. HOUR<br><b>4:45 PM</b>   |   |
| 3 SEX<br><b>Female</b>  |  | 4 RACE<br><b>White</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>1/15/1911</b>   |   | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>71</b> YRS.  |                                       | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.   |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>      |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.                       |                                       |  |   |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Good Samariten Hospital</b> |  |  |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Meat Wrapper</b> |                                       | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Food Chain</b>   |   |
| 13a. STATE<br><b>Maryland</b>   |  |   |  |  | 13b. COUNTY<br><b>Balto.</b>  |   | 13c. CITY OR TOWN<br><b>Parkville</b> |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Warren LaRue</b>   |  |   |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Laura Unknown</b> |   |                                       |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>213.12.2628</b>  |  | 17. INFORMANT<br><b>Vernon J. Norton</b> ADDRESS<br><b>Same as 13e</b>   |   |   |                                       |  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br><b>1629</b> IMMEDIATE CAUSE (a) <b>CEREBRAL METASTASIS</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>LAT CELL CARCINOMA (R) LUNG</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF (c) |  |   |  |  |   |   |                                       |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a  |  |   |  |  |   |   |                                       |  |   |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>    |                                       | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>19</b> P.M.   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)   |   |   |                                       |  |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |   |   |                                       |  |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>1-19-1982</b> , to <b>2-8-1982</b> , that (I) (we) last saw the deceased alive on <b>2-8-1982</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |   |  |  |   |   |                                       |  |   |
| 22b. SIGNATURE<br><i>[Signature]</i>  |  |   |  | DEGREE <b>M.D.</b><br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |   |   |                                       | 22c. DATE SIGNED<br><b>2-8-82</b>  |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>DR. ZAW MIN</b>   |  |   |  | 22e. ADDRESS<br><b>5601 LOCH RAVEN BLD. BALT.</b>  |   |   |                                       |  |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Cremation</b>  |  | 23b. DATE<br><b>2/9/1982</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Green Mount</b>   |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Balto. Md.</b>                         |                                       |  |   |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Walter Brooks Bradley Inc. Dundalk, Md. 21222</b>  |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>FEB 16 1982</b>  |   | 25b. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>  |                                       |  |   |

4 MAY 1964

WORLDWIDE AIRWAYS

WORLDWIDE

WORLDWIDE AIRWAYS  
WORLDWIDE AIRWAYS



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrars, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  |   |  |   |  |                        |  | 8 2 0 4 0 7 2   |     |  |          |
|--|--|---|--|---|--|---|--|------------------------|--|-----------------|-----|--|----------|
| 1. FOR STATE REGISTRAR   |  | REG. NO.  |  |   |  |   |  |                        |  |                 |     |  |          |
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  | FIRST   |  | MIDDLE  |  | LAST  |  | 2a. DATE OF DEATH      |  | MONTH           | DAY | YEAR   | 2b. HOUR |
| FRANK J. NOVAK   |  |   |  |   |  |   |  | 2-6-82                 |  |                 |     |  | 7:15 A M |
| 3. SEX   |  | 4. RACE   |  | 5. DATE OF BIRTH  |  | 6. AGE (IN YEARS LAST BIRTHDAY)                                     |  | IF UNDER 1 YEAR        |  | IF UNDER 24 HRS |     |  |          |
| Male   |  | White   |  | Jan, 24, 1905   |  | 77 YRS.   |  | MONTHS                 |  | DAYS            |     | HOURS MIN.                                   |          |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY?  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |  |                        |  |                 |     |  |          |
| Maryland   |  | U.S.A..   |  |   |  | Baltimore City,   |  |                        |  |                 |     | MD.  |          |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS OR INDUSTRY                                   |  |                        |  |                 |     |  |          |
| BALTIMORE  |  | Sinai Hospital  |  | Meat Cutter   |  | Food  |  |                        |  |                 |     |  |          |
| 13a. STATE   |  | 13b. COUNTY   |  | 13c. CITY OR TOWN   |  | 13d. INSIDE CITY LIMITS?  |  | 13e. STREET ADDRESS    |  |                 |     |  |          |
| Maryland   |  | 21239   |  | Baltimore   |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 1503 E. Northern Pkwy. |  |                 |     |  |          |
| 14. FATHER'S NAME  |  | 15. MOTHER'S MAIDEN NAME  |  |   |  |   |  |                        |  |                 |     |  |          |
| Frank  |  | Novak   |  | Katherine Josephine Handraech   |  |   |  |                        |  |                 |     |  |          |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)   |  | 17. INFORMANT   |  | ADDRESS   |  |                        |  |                 |     |  |          |
| No   |  | 212-07-0953   |  | Regina E. Novak   |  | Baltimore, MD 21239   |  |                        |  |                 |     |  |          |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>5188 IMMEDIATE CAUSE (a) <u>Respiratory failure</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Chronic lung disease</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u></u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |   |  |   |  |   |  |                        |  |                 |     | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |          |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)<br><u>lung bulla</u>  |  |   |  |   |  |   |  |                        |  |                 |     |  |          |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?      |  |                        |  |                 |     |  |          |
| 11-30-81   |  | Pneumothorax  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | YES <input type="checkbox"/> NO <input type="checkbox"/>            |  |                        |  |                 |     |  |          |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |                        |  |                 |     |  |          |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)                                     |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |                        |  |                 |     |  |          |
| 22a. I certify that (I) (this hospital) attended the deceased from 2-3, 19 82, to present, 19 82, that (I) (we) lost saw the deceased alive on 2-5, 19 82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (we) (did) (did not) view the body after death.  |  | 22b. SIGNATURE<br>Eve J. Schurman PA-C  |  | DEGREE<br>PA-C  |  | 22c. DATE SIGNED<br>2-6-82  |  |                        |  |                 |     |  |          |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  | 22e. ADDRESS  |  |   |  |   |  |                        |  |                 |     |  |          |
| EVE J. SCHURMAN  |  | Sinai Hosp.   |  |   |  |   |  |                        |  |                 |     |  |          |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  | 23b. DATE   |  | 23c. NAME OF CEMETERY OR CREMATORY  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE                          |  |                        |  |                 |     |  |          |
| Burial   |  | Feb. 9, '82   |  | Lorraine Park   |  | Baltimore Co., MD   |  |                        |  |                 |     |  |          |
| 24. FUNERAL DIRECTOR<br>NAME   |  | ADDRESS   |  | 25a. DATE REC'D. BY REGISTRAR   |  | 25b. REGISTRAR'S SIGNATURE  |  |                        |  |                 |     |  |          |
| William E. Johnson   |  | 8521 Loch Raven Blvd.   |  | FEB 8 1982  |  | [Signature]   |  |                        |  |                 |     |  |          |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  |   |  |   |  |  |  | REG. NO.<br>8 2 0 4 0 7 3  |  |                            |  |
|---|--|---|--|---|--|---|--|--|--|--|--|----------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Lilian K. O'Hair</b>   |  |   |  |   |  |   |  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>Feb 26 82</b>                            |  | 2b. HOUR<br><b>5:25P M</b> |  |
| 3. SEX<br><b>FEMALE</b>   |  | 4. RACE<br><b>WHITE</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>June 27, 1927</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>54</b> YRS.   |  | IF UNDER 1 YEAR<br>MONTHS DAYS   |  | IF UNDER 24 HRS.<br>HOURS MIN.   |  |                            |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>England</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.                               |  |  |  |  |  |                            |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>South Balto. General Hosp</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Homemaker</b>            |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |  |  |                            |  |
| 13a. STATE<br><b>Md.</b>  |  | 13b. COUNTY<br><b>A.A. Co.</b>  |  | 13c. CITY OR TOWN<br><b>Glen Burnie</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>6428 Jefferson Place</b>   |  |  |  |                            |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Stanley Keeling</b>  |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>unknown</b>   |  |   |  |  |  |  |  |                            |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>216 48 9740</b>  |  | 17. INFORMANT<br>ADDRESS<br><b>Jonathan O'Hair same as 13 e</b>   |  |   |  |  |  |  |  |                            |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Hypercalcemia</b><br><b>1991</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:<br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>Metastatic Adenocarcinoma</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) |  |   |  |   |  |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>2 months</b><br><b>4 months</b> |  |                            |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):  |  |   |  |   |  |   |  |  |  |  |  |                            |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |  |                            |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |  |   |  |  |  |  |  |                            |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |  |  |  |  |                            |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |   |  |   |  |   |  |  |  |  |  |                            |  |
| 22b. SIGNATURE<br><b>P Knits</b>  |  |   |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>        |  |   |  | 22c. DATE SIGNED<br><b>2/26/82</b>   |  |  |  |                            |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>P Knits</b>   |  |   |  | 22e. ADDRESS  |  |   |  |  |  |  |  |                            |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>3/2/82</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Cedar Hill Cemetery</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Brooklyn A.A. Md.</b>                          |  |  |  |  |  |                            |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>George J. Gonce</b>  |  |   |  | BALTO MD. 21225<br>ADDRESS<br><b>4001 Ritchie Hgwy</b>  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>MAR 1 1982</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><i>Thomas J. Gonce</i>   |  |  |  |                            |  |

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UNITED STATES OF AMERICA

MADE IN U.S.A.

THE UNITED STATES OF AMERICA

UNITED STATES OF AMERICA

UNITED STATES OF AMERICA

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The certificate should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with a 77-hour death certificate with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  |  |   |  |  |  |   |
|---|--|--|--|--|---|--|--|--|---|
| 1. FOR<br>STATE<br>REGISTRAR  |  |  |  |  | 8 2 0 4 0 7 4<br>REG. NO.   |  |  |  |   |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>BABY BOY OLIVER</b>   |  |  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>JANUARY 10 1982</b><br>2b. HOUR<br><b>1:41 AM</b> |  |  |  |   |
| 3 SEX<br><b>Male</b>  |  | 4. RACE<br><b>Black</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>January 8, 1982</b>   |   | 6 AGE (IN YEARS LAST BIRTHDAY)<br>YRS. MONTHS DAYS<br><b>2 2</b>   |  | IF UNDER 1 YEAR<br>IF UNDER 24 HRS.  |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U S A</b>   |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.   |  |  |   |
| 10 CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>St. Agnes Hospital</b> |  |  |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>none</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |   |
| 13a. STATE<br><b>Md</b>   |  | 13b. COUNTY<br><b>Balto</b>  |  | 13c. CITY OR TOWN<br><b>Arbutus</b>  |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 13e. STREET ADDRESS<br><b>2800 Gatehouse Dr 21227</b>  |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>unknown</b>  |  |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Marguerite T. Oliver</b>                |  |  |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>no</b>   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>none</b>   |  | 17. INFORMANT<br>ADDRESS<br><b>Marguerite T. Oliver, 2800 Gatehouse Dr.</b>  |   |  |  |  |   |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Disseminated IntraVascular Coagulation</b><br><b>7678</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Subcapsular Hematoma of Liver</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>BIRTH TRAUMA</b> |  |  |  |  |   |  |  |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a)  |  |  |  |  |   |  |  |  |   |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  |   | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)   |   |  |  |  |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |   |  |  |  |   |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost<br>saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.       |  |  |  |  |   |  |  |  |   |
| 22b. SIGNATURE<br><b>Bert F. Morton M.O.</b>  |  |  |  |  |   | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br><b>1/10/82</b>   |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>BERT F. MORTON</b>  |  |  |  |  |   | 22e. ADDRESS   |  |  |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>   |  | 23b. DATE<br><b>3/4/82</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>NEW CATHEDRAL</b>   |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>4300 OLD FREDK. RD., BALTO., MD.</b>  |  |  |   |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>WITZKE FUN'L HOME, 1630 EDMONDSON AVE. BALTIMORE, MD.</b>  |  |  |  |  |   | 25a. DATE REC'D. BY REGISTRAR<br><b>MAR 2 1982</b><br>25b. REGISTRAR'S SIGNATURE<br><i>James Santhron</i>  |  |  |   |

MEDICAL CERTIFICATION

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NOTED, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |  |                      |  |  |  |  |  |  |  | REG. NO. 0-4075   |  |
|--|--|----------------------|--|--|--|--|--|--|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>William O'Neill</b>   |  |                      |  |  |  | 2a. DATE KNOWN OF DEATH<br>ESTIMATED <input checked="" type="checkbox"/> MONTH <b>2</b> DAY <b>16</b> YEAR <b>1982</b> |  | 2b. HOUR <b>9:31</b> AM  |  |   |  |
| 3. SEX <b>male</b>   |  | 4. RACE <b>black</b> |  | 5. DATE OF BIRTH<br>MONTH <b>9</b> DAY <b>2</b> YEAR <b>17</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY) <b>64</b> YRS.   |  | 7. IF UNDER 1 YR. MONTHS <b>0</b> DAYS <b>0</b> HOURS <b>0</b> MIN <b>0</b>  |  | 7c. DATE PRONOUNCED DEAD<br>MONTH <b>2</b> DAY <b>16</b> YEAR <b>1982</b> |  |
| 7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>VIRGINIA</b>  |  |                      |  | 7b. CITIZEN OF WHAT COUNTRY? <b>US</b>   |  |  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.            |  |
| 10. CITY OR TOWN OF DEATH <b>Baltimore</b>   |  |                      |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>417 East 24th Street</b> |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| 13a. STATE <b>MARYLAND</b>   |  |                      |  | 13b. COUNTY  |  | 13c. CITY OR TOWN <b>BALTIMORE</b>   |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 13e. STREET ADDRESS <b>417 E. 24th ST.</b>                                |  |
| 14. FATHER'S NAME<br>FIRST <b>SIM</b> MIDDLE <b>O NEIL</b> LAST <b>RACHEAL</b>   |  |                      |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>RACHEAL</b> MIDDLE <b>BRACEY</b> LAST <b>BRACEY</b>                               |  |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)   |  |                      |  | 16b. SOCIAL SECURITY NO. <b>231-10-6020</b>  |  | 17. INFORMANT ADDRESS <b>DOROTHY LITCHFIELD NORFOLK, VA.</b>   |  |  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Arteriosclerotic cardiovascular disease</b><br><b>4292</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last:<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____   |  |                      |  |  |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                              |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____  |  |                      |  |  |  |  |  |  |  |   |  |
| 19a. DATE OF OPERATION   |  |                      |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  |  |  | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |   |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  |                      |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. <b>19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)  |  |  |  |   |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |                      |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |  |   |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |                      |  |  |  |  |  |  |  |   |  |
| ACTUAL SIGNATURE <b>[Signature]</b> M.D. <b>Assistant</b>  |  |                      |  |  |  | TITLE (SPECIFY) <b>Assistant</b> MEDICAL EXAMINER  |  | DATE SIGNED <b>2/16/82</b>   |  |   |  |
| EXAMINER'S NAME (TYPE OR PRINT) <b>Hormez R. Guard, M.D.</b>   |  |                      |  |  |  | ADDRESS <b>111 Penn Street, Balto., MD 21201</b>   |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (S) <b>REMOVAL</b>   |  |                      |  | 23b. DATE <b>2-19-82</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY <b>ROOSEVELT MEMORIAL</b>   |  | 23d. LOCATION<br>CITY OR TOWN <b>CHEASPEAKE</b> COUNTY <b>VIRGINIA</b> STATE   |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME <b>E.L. PHILLIPS</b> ADDRESS <b>1721 N. MONROE ST.</b>  |  |                      |  |  |  | 25a. DATE REC'D. BY REGISTRAR <b>FEB 18 1982</b>   |  | 25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>  |  |   |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |   |  |  |  |  |  |
|--|--|--|--|---|--|--|--|--|--|
| 1. FOR STATE REGISTRAR   |  | REG. NO.   |  | 82 04076  |  |  |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <i>Oseroff</i> <b>MORRIS</b> <i>Morris</i> <b>OSEROFF</b>  |  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>2 15 82</b>   |  | 2b. HOUR <b>10 P.M.</b>  |  |  |  |
| 3. SEX<br><b>M</b> <b>MALE</b>   |  | 4. RACE<br><b>W</b> <b>HITE</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>MAR. 7, 1906</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>75</b> YRS.  |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MARYLAND</b>   |  | 7b. CITIZEN OF, WHAT COUNTRY?<br><b>USA</b>  |  | 8. MARRIAGE STATUS<br><input checked="" type="checkbox"/> NEVER MARRIED<br><input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED |  | 9. <b>BALTIMORE CITY</b> OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>SINAI HOSPITAL</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>EXECUTIVE</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>COM. PLUMBING</b>  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |  |  |   |  |  |  |  |  |
| 13a. STATE<br><b>MARYLAND</b>  |  | 13b. COUNTY<br><b>BALTO.</b>   |  | 13c. CITY OR TOWN<br><b>BALTIMORE</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 13e. STREET ADDRESS<br><b>6318 GREENSPRING AVE. 21209</b>  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>NATHAN OSEROFF</b>  |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>LENA WARSBAWSKY</b>   |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>NO</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>215-32-9888</b>   |  | 17. INFORMANT<br>ADDRESS<br><b>MRS. SYLVIA OSEROFF APT. 304 6318 GREENSPRING AVE. BALTO., MD 21209</b>  |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Acute Myocardial Infarction</b><br><b>4100</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>Arteriosclerotic Heart Disease</b><br>DUE TO, OR AS A CONSEQUENCE OF (c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>2 hours</b> |  |  |  |   |  |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)<br><b>Peripheral Vascular Disease</b>   |  |  |  |   |  |  |  |  |  |
| 19a. DATE OF OPERATION<br><b>—</b>   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>—</b>   |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. — 19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)<br><b>—</b>  |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)<br><b>—</b>   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br><b>—</b>   |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>April 2/15/82</b> to <b>Feb 19 82</b> , that (I) (we) lost<br>saw the deceased alive on <b>2/15/82</b> above, (I) (we) (did/did not) view the body after death, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated                                    |  |  |  |   |  |  |  |  |  |
| 22b. SIGNATURE<br><i>Robert L. Levy</i> MD   |  |  |  | DEGREE<br><b>MD</b>   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 72c. DATE SIGNED<br><b>2/15/82</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Robert L. Levy MD</b>  |  |  |  | 22e. ADDRESS<br><b>Sinai Hospital - Baltimore Md.</b>   |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY) <b>BURIAL</b>   |  | 23b. DATE<br><b>FEB. 17, 1982</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>AITZ CHAIM</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>BALTIMORE MARYLAND</b>  |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>SOL LEVINSON &amp; BROS., INC. 6010 REISTERSTOWN RD. BALTO., MD 21215</b>   |  |  |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>FEB 24 1982</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><i>Thomas J. ...</i>   |  |

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FEB 24 1985

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.DHMH - 16 50M 7/77  
(VR A 15 (4))STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

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1 - FOR  
STATE  
REGISTRAR

REG. NO.

|   |  |   |   |  |  |  |  |
|---|--|---|---|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>WALTER ADAM OTREMBKA   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>2 25 82                                  |  |  | 2b. HOUR<br>5:50 A M   |  |
| 3. SEX<br>M   | 4. RACE<br>W   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>4 3 16  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>65 YRS                                       |  | IF UNDER 1 YEAR<br>MONTHS DAYS                   |  | IF UNDER 24 HRS.<br>HOURS MIN                |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br>MD  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Balt City MD                            |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Balt   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>S B G H |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>auto worker |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Gen. Motors |  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>MD  |  | 13b. CITY OR TOWN<br>Balt   | 13c. CITY OR TOWN<br>Balt   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  | 13e. STREET ADDRESS<br>703 Oakleigh Beach Rd.    |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>FRANK OTREMBKA  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>TINI KOTOWSKI  |   |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>UNK   |  | 16b. SOCIAL SECURITY NO.<br>215-10-9419   |   | 17. INFORMANT<br>G. HALLICK  |  | ADDRESS<br>3001 S Hanover St   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Cardiac shock<br>4100<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) myocardial infarction<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |   |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)<br>Diabetes + gangrene of R foot  |  |   |   |  |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |  |
| 22a. I certify that (a) this hospital attended the deceased from 12/30, 1981, to 2/25, 1982, that (b) (we) lost saw the deceased alive on 2/25, 1982, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (b) (we) (did) (did not) view the body after death.  |  |   |   |  |  |  |  |
| 22b. SIGNATURE<br>G. Hallick  |  |   |   | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br>2/25/82  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>HALLICK  |  |   |   | 22e. ADDRESS<br>3001 S. HANOVER ST   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>BURIAL  |  | 23b. DATE<br>3/1/82   |   | 23c. NAME OF CEMETERY OR CREMATORY<br>HOLY ROSARY  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>BALTO. MD  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>J.G. CONNELLY   |  |   |   | ADDRESS<br>300 MACE  |  | 25a. DATE REC'D. BY REGISTRAR<br>FEB 26 1982   |  |
|   |  |   |   |  |  | 25b. REGISTRAR'S SIGNATURE<br>Charles Van Natten   |  |

MEDICAL CERTIFICATION

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9  
1

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 4 0 7 3

REG. NO.

|  |  |   |   |  |  |   |  |  |   |  |
|--|--|---|---|--|--|---|--|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>ROBERT EARL OTTO</b>   |  |   | 2a. DATE OF DEATH<br>MONTH <b>2</b> DAY <b>7</b> YEAR <b>82</b>                   |  |  | 2b. HOUR<br><b>2:10PM</b>   |  |  |   |  |
| 3. SEX<br><b>MALE</b>  |  | 4. RACE<br><b>WHITE</b>   |   | 5. DATE OF BIRTH<br>MONTH <b>3</b> DAY <b>16</b> YEAR <b>23</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>58</b> YRS.   |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.  |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MARYLAND</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE, CITY</b> MD.  |  |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br><b>VAMC, 3900 LOCH RAVEN BLVD.</b> |   |  |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>DISABLED</b>                                     |  | 12b. KIND OF BUSINESS OR INDUSTRY  |   |  |
| 13a. STATE<br><b>MD.</b>   |  |   | 13b. COUNTY<br><b>BALTO.</b>  |  |  | 13c. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                         |  |  | 13d. STREET ADDRESS<br><b>905 S. LUZERNE AVE.</b> |  |
| 14. FATHER'S NAME<br><b>EMILE</b> MIDDLE <b>OTTO</b> LAST <b>OTTO</b>  |  |   | 15. MOTHER'S MAIDEN NAME<br><b>MARY</b> MIDDLE <b>SCHWIDT</b> LAST <b>SCHWIDT</b> |  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>YES</b> (IF YES, GIVE WAR OR DATES) <b>WWII</b> |  |  |   |  |
| 16b. SOCIAL SECURITY NO.<br><b>220 14 2472</b>   |  |   | 17. INFORMANT<br><b>DOROTHY LAVAGNINO</b>   |  |  | ADDRESS<br><b>6700 GLENKIRK RD.</b>   |  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <b>Cardiopulmonary Arrest</b><br>1991<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) <b>metastatic Squamous Cell Carcinoma</b><br>(c) <b>metastatic Squamous Cell Carcinoma</b>   |  |   |   |  |  |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH      |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>1991</b>   |  |   |   |  |  |   |  |  |   |  |
| 19a. DATE OF OPERATION   |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                  |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                        |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |  |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)            |  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |   |  |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>1-21</b> , 19 <b>82</b> , to <b>2-7-</b> , 19 <b>82</b> , <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>2-7-</b> , 19 <b>82</b> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) <input checked="" type="checkbox"/> (not) view the body after death. |  |   |   |  |  |   |  |  |   |  |
| 22b. SIGNATURE<br><b>Robert H. Levitt MD</b> DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>  |  |   |   |  |  | 22c. DATE SIGNED  |  |  |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Robert H. Levitt MD</b>  |  |   |   |  |  | 22e. ADDRESS<br><b>BALTO.</b>   |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>  |  |   | 23b. DATE<br><b>2-10-82</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>BALTO. CEM.</b> |   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY<br><b>BALTO.</b>  |   |  |
| 24. FUNERAL DIRECTOR<br><b>HEFFMANN-SHARDA</b> ADDRESS<br><b>3218 HUDSON ST.</b>   |  |   |   |  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>FEB 9 1982</b>  |  |  |   |  |

1907:2 01 7 12  
OTTO J. A. E.  
WHITE  
U.S.N.  
BARTHOLOME  
WANG, 3000 N. 10th Street

MR. J. A. E.  
C. T. O.  
WANG, 3000 N. 10th Street  
BARTHOLOME

1-2-2 1-2-2 1-2-2 1-2-2 1-2-2 1-2-2 1-2-2 1-2-2 1-2-2 1-2-2

1-2-2 1-2-2 1-2-2 1-2-2 1-2-2 1-2-2 1-2-2 1-2-2 1-2-2 1-2-2



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 50M 1/81  
(VRA 15, 4)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 4 0 7 9

REG. NO.

|  |   |  |   |  |                                   |  |          |
|--|---|--|---|--|-----------------------------------|--|----------|
| 1. FOR STATE REGISTRAR   |   | 2a. DATE OF DEATH  |   | MONTH  | DAY                               | YEAR   | 2b. HOUR |
| 1 DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br>Harry F. Owens, Jr.  |   | 1 2  |   | 22   | 82                                |  | 3:15 PM  |
| 3 SEX  | 4 RACE  | 5 DATE OF BIRTH  | 6 AGE   | IF UNDER 1 YEAR  |                                   | IF UNDER 74 HRS.   |          |
| Male   | White   | 2 MONTH 24 DAY 10 YEAR   | 71 YRS  | MONTHS DAYS  |                                   | HOURS MIN.   |          |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)   | 7b. CITIZEN OF WHAT COUNTRY?  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9 BALTIMORE CITY OR COUNTY OF DEATH                                 |  |                                   |  |          |
| MARYLAND   | USA   |  | Baltimore City MD.  |  |                                   |  |          |
| 10. CITY OR TOWN OF DEATH  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)    |  | 12b. KIND OF BUSINESS OR INDUSTRY |  |          |
| Baltimore  | South Baltimore Gen. Hosp.  |  | ELECTRICIAN   |  |                                   |  |          |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |   | 13b. CITY OR TOWN  | 13c. INSIDE CITY LIMITS?  | 13d. STREET ADDRESS  |                                   |  |          |
| MD BALT.   |   | English Consulate  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 3520 Annapolis Rd.   |                                   |  |          |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST  |   | 16. G. Washington La.  |                                   |  |          |
| HARRY F OWENS, SR.   |   | Mildredrein KEECH  |   |  |                                   |  |          |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)   |   | 16b. SOCIAL SECURITY NO.   |   | 17 INFORMANT   |                                   |  |          |
| YES  |   | 1927- 1930   |   | Mrs. Millierein Buck Westminster, Md. 21157                                    |                                   |  |          |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1: DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) 4275 CARDIAC-PULMONARY ARREST<br>DUE TO, OR AS A CONSEQUENCE OF (b) RESPIRATORY FAILURE<br>DUE TO, OR AS A CONSEQUENCE OF (c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 45 minutes |   |  |   |  |                                   |  |          |
| PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a<br>COPD, Hypertension, (L) AKA.   |   |  |   |  |                                   |  |          |
| 19a. DATE OF OPERATION   |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   | 20a. AUTOPSY?  |                                   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |          |
|  |   |  |   | YES <input type="checkbox"/> NO <input type="checkbox"/>                       |                                   | YES <input type="checkbox"/> NO <input type="checkbox"/>       |          |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2) |                                   |  |          |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |                                   |  |          |
| 22a. I certify that (I) (this hospital) attended the deceased from 1/15 19 82 to 2/22 19 82, that (I) (we) last saw the deceased alive on 2/22 19 82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.           |   | 22b. SIGNATURE<br>Andrew Shankman, M.D.  |   | 22c. DATE SIGNED<br>2-22-82  |                                   |  |          |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Andrew Shankman, M.D.   |   | 22e. ADDRESS<br>South Baltimore General Hospital<br>Baltimore, Md.   |   |  |                                   |  |          |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)   |   | 23b. DATE  |   | 23c. NAME OF CEMETERY OR CREMATORY   |                                   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE                     |          |
| Burial   |   | 2/26/82  |   | Greenmount Cemetery  |                                   | Baltimore City MD  |          |
| 24. FUNERAL DIRECTOR<br>NAME Loring Byers Funeral Directors, INC.<br>ADDRESS 8728 Liberty Rd. Randallstown, Md. 21133  |   |  |   | 25. DATE REC'D. BY REGISTRAR 25. REGISTRAR'S SIGNATURE<br>FEB 25 1982          |                                   |  |          |

MEDICAL CERTIFICATION

1

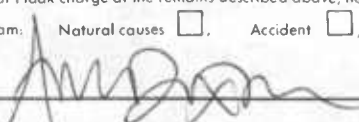



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS ENCOUNTERED, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 WITH YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

|  |                  |   |  |   |  |   |   |  |  |
|--|------------------|---|--|---|--|---|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>NOREEN OWENS</b>  |                  |   | 2a. DATE KNOWN OF DEATH<br>MONTH <input checked="" type="checkbox"/> 2 DAY 5 YEAR 1982 |   |  | 2b. HOUR<br>M 8:40 P 0  |   |  |  |
| 3. SEX<br>female   | 4. RACE<br>negro | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>Nov. 26 48  | 6. AGE (IN YEARS)<br>LAST BIRTHDAY YRS. 35   | IF UNDER 1 YR.<br>MONTHS DAYS HOURS MIN.  | 7c. DATE PRONOUNCED DEAD<br>MONTH DAY YEAR<br>2 5 1982   | 2d. HOUR<br>M 8:40 P 0  |   |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Wilmington, Del.  |                  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.  |   |  |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore   |                  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>University Hospital |  |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>unemployed                        |   | 12b. KIND OF BUSINESS OR INDUSTRY   |  |  |
| 13a. STATE<br>Md.  |                  | 13b. COUNTY   |  | 13c. CITY OR TOWN<br>Balto.   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>    |   | 13e. STREET ADDRESS<br>3457 Childs Ct.  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Charles Owens  |                  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Catherine Clayborn                    |   |  |   |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br>no  |                  | (IF YES, GIVE WAR OR DATES)   |  | 16b. SOCIAL SECURITY NO.<br>222-36-1019   |  | 17. INFORMANT<br>ADDRESS<br>Linda Hudnell 4108 Rollins Ave.   |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Gunshot wound of head (handgun)</u><br>9650<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b) _____<br>(c) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>DUE TO, OR AS A CONSEQUENCE OF  |                  |   |  |   |  |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).  |                  |   |  |   |  |   |   |  |  |
| 19a. DATE OF OPERATION   |                  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                                      |   |  |   | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |                  |   | 21b. TIME OF INJURY<br>HOUR <del>XX</del> MONTH DAY YEAR<br>8:40 P.M. 2-4- 1982        |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)<br>Subject was shot. |   |   |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/><br>AT WORK AT WORK   |                  |   | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)<br>home                    |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br>3457 Childs Ct. Balto. Del. Md.               |   |   |  |  |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> . |                  |   |  |   |  |   |   |  |  |
| ACTUAL SIGNATURE<br>  |                  |   | TITLE (SPECIFY)<br>M.D. Assistant MEDICAL EXAMINER                                     |   |  |   | DATE SIGNED<br>2-6-82   |  |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)<br>Ann M. Dixon, M.D.   |                  |   | ADDRESS<br>111 Penn St.  |   |  |   |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial   |                  | 23b. DATE<br>2-12-82  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Mt. Zion Cemetery   |  |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Wilmington Del.                       |  |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br>Carlton C. Douglass 1012 Penn. Ave.  |                  |   |  | 25a. DATE REC'D. BY REGISTRAR<br>FEB 9 1982   |  | 25b. REGISTRAR'S SIGNATURE<br> |   |  |  |

2000 GOLDEN GLOBE

THE NEW YORK TIMES



1- FOR  
STATE  
REGISTRAR

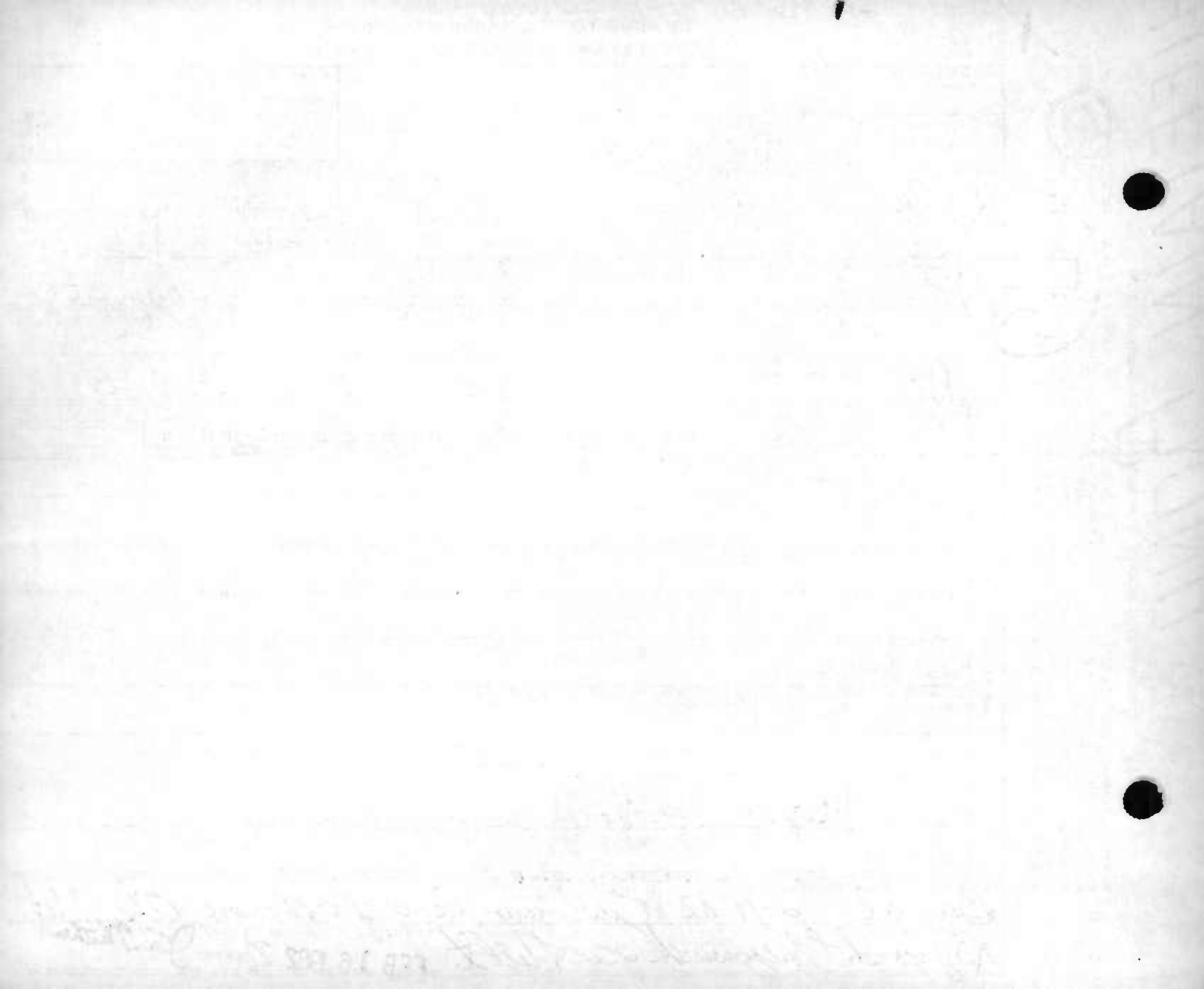
## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

|   |                         |   |   |   |   |   |   |  |
|---|-------------------------|---|---|---|---|---|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>MARY A. OXIER</b>   |                         |   | 2a. DATE KNOWN OF DEATH<br>ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR<br><b>2-5-82</b> 19 |   |   | 2b. HOUR<br>M<br><b>8:20</b> A<br>M   |   |  |
| 3. SEX<br><b>female</b>   | 4. RACE<br><b>white</b> | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>March 4 1934</b> 47 YRS.   | 6. AGE (IN YEARS)<br>(LAST BIRTHDAY)<br><b>47</b>   | IF UNDER 1 YR.<br>MONTHS DAYS HOURS MIN.  | IF UNDER 24 HRS.<br>HOURS MIN.  | 7c. DATE PRONOUNCED DEAD<br>MONTH DAY YEAR<br><b>2-5-82</b> 19                                  |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>W. Va.</b>  |                         | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.                               |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   |                         | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>221 S. Durham Street</b> |   |   |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Homemaker</b>               |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>None</b> |
| 13a. STATE<br><b>MD</b>   |                         |   | 13b. COUNTY   |   | 13c. CITY OR TOWN   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST  |                         |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST   |   |   | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NOT OR UNKNOWN) <b>No</b>                 |   |  |
| 16b. SOCIAL SECURITY NO.  |                         |   | 17. INFORMANT<br><b>Sadie Kachta</b>  |   |   | ADDRESS<br><b>1722 Bough St.</b>  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br><b>7455</b> IMMEDIATE CAUSE (a) <b>Atrial septal defect and chronic pericarditis</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last:<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____   |                         |   |   |   |   |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH     |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).   |                         |   |   |   |   |   |   |  |
| 19a. DATE OF OPERATION  |                         |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |   |   |   | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |                         |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART 1 OR PART 2) |   |   |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |                         |   | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                             |   |   |  |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |                         |   |   |   |   |   |   |  |
| ACTUAL SIGNATURE<br><b>Margie McNeill</b>   |                         |   | TITLE (SPECIFY)<br><b>M.D. Assistant</b>  |   |   | DATE SIGNED<br><b>2-5-82</b>  |   |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)<br><b>Margarita A. Korell, M.D.</b>  |                         |   | ADDRESS<br><b>111 Penn Street</b>   |   |   |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |                         |   | 23b. DATE<br><b>2-11-82</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Eastview Cem</b>                     |   | 23d. LOCATION<br>(CITY OR TOWN) COUNTY<br><b>Baltimore City, Md.</b>                |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Raymond J. Kaczmarek</b>   |                         |   | ADDRESS<br><b>2525 Thoburn</b>  |   |   | 25a. DATE REC'D. BY REGISTRAR<br><b>FEB 16 1982</b>   |   |  |
| 25b. REGISTRAR'S SIGNATURE<br><b>Frances</b>  |                         |   | 25c. REGISTRAR'S NAME<br><b>Frances</b>   |   |   |   |   |  |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL HOME. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  | REG. NO. 8 2 0 4 0 8 2   |  |   |  |
|--|--|--|--|--|--|---|--|
| 1. FOR STATE REGISTRAR   |  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR 2/ 19/ 82   |  |   |  |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Mary Ellen Parham   |  |  |  | 2b. HOUR M   |  |   |  |
| 3. SEX Female  |  | 4. RACE Blk  |  | 5. DATE OF BIRTH MONTH DAY YEAR 8- 5- 10   |  | 6. AGE (IN YEARS LAST BIRTHDAY) 71 YRS.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md   |  | 7b. CITIZEN OF WHAT COUNTRY? U.S.A   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH City MD.   |  |
| 10. CITY OR TOWN OF DEATH Baltimore  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 2012 Etting St. |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| 13a. STATE Md  |  | 13b. COUNTY Balto  |  | 13c. CITY OR TOWN Balto  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST May A. Coates   |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)  |  |   |  |
| 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT ADDRESS Josephine Davis 2032 Etting St.  |  |  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Possible Myocardial infarction<br>4100<br>DUE TO, OR AS A CONSEQUENCE OF (b) ARTERIOSCLEROTIC CARDIOVASC. DISEASE<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF (c) |  |  |  |  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) DIABETES   |  |  |  |  |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from APRIL 19 80, to NOV 19 1981, that (I) (we) last saw the deceased alive on NOV 14 19 81, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |  |  |  |  |   |  |
| 22b. SIGNATURE Donato A. Vargas Jr, M.D.   |  | DEGREE M.D.  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>               |  | 22c. DATE SIGNED  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) DONATO A. VARGAS JR  |  | 22e. ADDRESS 1618 W. NORTH AVE BALTO MD 21217  |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial   |  | 23b. DATE 2/24/82  |  | 23c. NAME OF CEMETERY OR CREMATORY Arbutus Cem.  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Md  |  |
| 24. FUNERAL DIRECTOR NAME Vernon   |  | R. Bailey 1348 N. Calhoun St   |  | 25a. DATE REC'D. BY REGISTRAR FEB 23 1982  |  | 25b. REGISTRAR'S SIGNATURE Thomas J. North  |  |



*[Faint, illegible text and markings covering the majority of the page, possibly bleed-through from the reverse side.]*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrars, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in the office after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

1. FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |   |   |  |  |  |
|--|--|--|---|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Joseph E. Parker  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>Feb 15 '82 |   |  | 2b. HOUR<br>12 45 M  |  |
| 3. SEX<br>Male   |  | 4. RACE<br>White   |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>Feb. 20, 1910   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>71 YRS.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Balto. Md City MD.   |  |
| 10. CITY OR TOWN OF DEATH<br>Balto.  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Union Memorial Hospital |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Retired   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Rail Road   |  |
| 13a. STATE<br>Maryland   |  | 13b. COUNTY<br>Baltimore   |   | 13c. CITY OR TOWN<br>Towson   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input checked="" type="checkbox"/>                 |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Horatio J. Parker  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Beatrice Ellis  |   | 13e. STREET ADDRESS<br>6507 Loch Hill Court   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>705 09 3397   |   | 17. INFORMANT<br>ADDRESS<br>Mrs. Marie E. Parker Same   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) PNEUMONIA (FULMINANT)<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. |  |  |   |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br>DIABETES; HISTORY OF GI BLEED   |  |  |   |   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a. I certify that (this hospital) attended the deceased from JAN 18, 19 82, to FEB 15, 19 82, that (we) lost saw the deceased alive on FEB 15 19 82, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I we) (did) (did not) saw the body after death.   |  |  |   |   |  |  |  |
| 22b. SIGNATURE<br>J. Kelly - DOK LIBO MD   |  | DEGREE<br>M.D.   |   | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>                  |  | 22c. DATE SIGNED<br>FEB. 15, 1982  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>J. Kelly - DOK LIBO MD.   |  | 22e. ADDRESS<br>201 E. UNIVERSITY PARKWAY  |   |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial  |  | 23b. DATE<br>2/16/82   |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Moreland  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Balto. Md.   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Henry W. Jenkins & Sons Co.<br>4905 York Road Balto., Md. 21212  |  |  |   | 25a. DATE REC'D. BY REGISTRAR<br>FEB 16 1982  |  | 25b. REGISTRAR'S SIGNATURE<br>Anne J. Smith  |  |



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STATE  
REGISTRAR

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|---|--|--|--|--|--|--|--|---|--|--|--|
| 1. DECEASED NAME<br>(Type or Print) <b>Principi, A</b>  |  | FIRST <b>A</b>   |  | MIDDLE <b>L</b>  |  | LAST <b>Tarker</b>   |  | 2a. DATE OF DEATH MONTH <b>2</b> DAY <b>23</b> YEAR <b>82</b>   |  | 2b. HOUR <b>7:35</b> AM <b>A</b>               |  |
| 3. SEX <b>Female</b>  |  | 4. RACE <b>Black</b>   |  | 5. DATE OF BIRTH MONTH <b>4</b> DAY <b>16</b> YEAR <b>20</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY) <b>61</b> YRS  |  | 7. IF UNDER 1 YEAR MONTHS <b></b> DAYS <b></b>  |  | 8. IF UNDER 24 HRS. HOURS <b></b> MIN. <b></b> |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>New Jersey</b>   |  | 7b. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTO. CITY</b> MD                                   |  |   |  |  |  |
| 10. CITY OR TOWN OF DEATH <b>Baltimore</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Key Circle Hospice</b> |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY <b>House work</b>  |  |   |  |  |  |
| 13a. STATE <b>MD</b>  |  | 13b. COUNTY <b>BALTO.</b>  |  | 13c. CITY OR TOWN <b>BALTO.</b>  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS <b>1214 E. Taw Trace</b>  |  |  |  |
| 14. FATHER'S NAME FIRST <b>Daniel</b> MIDDLE <b></b> LAST <b>Dunn</b>   |  | 15. MOTHER'S MAIDEN NAME FIRST <b>Clara</b> MIDDLE <b></b> LAST <b>Kell</b>  |  |  |  |  |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>   |  | 16b. SOCIAL SECURITY NO. <b>218-82-3349</b>  |  | 17. INFORMANT <b>Barbara Owens - Daughter</b> ADDRESS <b>2511 Calverton Apts. Ave.</b>   |  |  |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))  |  |  |  |  |  |  |  |   |  |  |  |
| PART 1. DEATH WAS CAUSED BY:  |  |  |  |  |  |  |  |   |  |  |  |
| IMMEDIATE CAUSE (a) <b>Cardiac Arrest</b>   |  |  |  |  |  |  |  |   |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF (b) <b>Coronary art. Sclerosis</b>   |  |  |  |  |  |  |  |   |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF (c) <b>ASCUD</b>   |  |  |  |  |  |  |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <b>Chronic Brain Syndrome due C.A.S. + Dial. Hdl.</b>  |  |  |  |  |  |  |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>                       |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR <b>A.M.</b> MONTH <b>19</b> DAY <b>19</b> YEAR <b>81</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |  |   |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET   |  | CITY OR TOWN   |  | COUNTY  |  | STATE  |  |
| 22a. I certify that (this hospital) attended the deceased from <b>July 1</b> , 19 <b>81</b> , to <b>Feb 23</b> , 19 <b>82</b> , that (we) lost above, the deceased alive on <b>2/4/82</b> , 19 <b></b> , and that in (my) <b>(our)</b> opinion death occurred on the date and hour and from the causes stated above, (I) <b>(we)</b> (did not) view the body after death. |  |  |  |  |  |  |  |   |  |  |  |
| 22b. SIGNATURE <b>Kenneth Kulecorty MD</b>  |  | DEGREE <b>MD</b>   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>               |  |  |  | 22c. DATE SIGNED <b>2/23/82</b>   |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  | 22e. ADDRESS   |  |  |  |  |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>   |  | 23b. DATE <b>2/27/82</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY <b>MT AUSTIN</b>  |  | 23d. LOCATION CITY OR TOWN <b>BALTO MD</b> COUNTY <b></b> STATE <b></b>                      |  |   |  |  |  |
| 24. FUNERAL DIRECTOR NAME <b>Marion Williams</b>  |  | 25a. DATE REC'D. BY REGISTRAR <b>FEB 24 1982</b>   |  | 25b. REGISTRAR'S SIGNATURE <b>Rose Jean Norton</b>   |  |  |  |   |  |  |  |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  | 8 2 0 4 0 8 5   |  |  |  |
|---|--|--|--|---|--|--|--|
| 1. FOR STATE REGISTRAR  |  |  |  | REG. NO.  |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br><b>WILLIAM MICHAEL PARKER</b>  |  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>2 2 82</b>   |  | 2b. HOUR<br><b>6:15A M</b>   |  |
| 3. SEX<br><b>MALE</b>   |  | 4. RACE<br><b>WHITE</b>  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>6 1 00</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY) YRS.<br><b>81</b>  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN)<br><b>MARYLAND</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE, CITY</b> MD.   |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br><b>VAMC, LOCH RAVEN BLVD BALTO. MD.</b> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>WELDER</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>STEEL MFR.</b>   |  |
| 13a. STATE<br><b>MARYLAND</b>   |  |  |  | 13b. COUNTY<br><b>BALTIMORE</b>   |  | 13c. CITY OR TOWN<br><b>DUNDALK</b>  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>HENRY PARKER</b>  |  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>EMILY UNKNOWN</b>  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>YES</b>  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>WWI</b>                              |  | 17. INFORMANT<br><b>VAMC LOCH RAVEN RECORDS</b>   |  | ADDRESS  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiopulmonary Arrest</b><br><b>4275</b> DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>END STAGE HEART &amp; LUNG DISEASE</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                        |  |  |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>CHRONIC RENAL FAILURE / NEPHROLITHIASIS</b>   |  |  |  |   |  |  |  |
| 19a. DATE OF OPERATION<br><b>None</b>   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>                                  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                             |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a. I certify that <b>XX</b> (this hospital) attended the deceased from <b>JANUARY 20, 1982</b> to <b>FEBRUARY 2, 1982</b> , that <b>X</b> (we) last saw the deceased alive on <b>JAN FEB. 2, 1982</b> , and that in <b>X</b> (our) opinion death occurred on the date and hour and from the causes stated above, <b>(X)</b> (we) (did) (did not) view the body after death. |  |  |  |   |  |  |  |
| 22b. SIGNATURE<br><b>Arthur J. Lomant MD PhD</b>  |  | DEGREE   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                  |  | 22c. DATE SIGNED<br><b>2/2/82</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Arthur J. Lomant</b>  |  |  |  | 22e. ADDRESS<br><b>3900 LOCH RAVEN BLVD. BALTO. MD 21218</b>  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>   |  | 23b. DATE<br><b>2/5/1982</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>St. Stanislaus Cem.</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Maryland</b>  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Walter Brooks Bradley Inc., Dundalk Md 21222</b>   |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>FEB 5 1982</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Francis J. [Signature]</b>  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requirement for the certificate be executed within 48 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of date.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  | REG. NO. 8 2 0 4 0 8 5  |  |   |  |
|--|--|--|--|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>ROBERT PAULSON</b>  |  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>FEBRUARY 26, 1982</b>   |  | 2b. HOUR<br><b>3:10AM</b>   |  |
| 3. SEX<br><b>MALE</b>  |  | 4. RACE<br><b>WHITE</b>  |  | 5. DATE OF BIRTH<br><b>FEB. 11, 1908</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>74</b>  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MARYLAND</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.   |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>JOHNS HOPKINS HOSPITAL</b> |  | 12a. USUAL OCCUPATION<br>(TYPE OR NATURE OF WORKING LIFE)<br><b>GROCER</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>FOODS</b>   |  |
| 13a. STATE<br><b>MARYLAND</b>  |  |  |  | 13b. COUNTY<br><b>BALTIMORE</b>   |  | 13c. CITY OR TOWN<br><b>BALTIMORE</b>   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>LOUIS PAULSON</b>   |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>ROSE ROSENFELD</b>  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>NO</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>213-01-8485</b>   |  | 17. INFORMANT<br><b>MRS. EDNA PAULSON</b><br><b>2706 HANSON AVE. BALTO., MD 21209</b>   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Pulmonary edema</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Congestive Heart failure</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Status Post Myocardial Infarct</b>  |  |  |  |   |  |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br><b>3 days</b><br><b>2 years</b><br><b>2 years</b> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><b>Chronic Renal failure</b>   |  |  |  |   |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>2/22</b> , 19 <b>82</b> , to <b>2/26</b> , 19 <b>82</b> , that (I) (we) last saw the deceased alive on <b>3:05pm</b> , 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) did not view the body after death. |  |  |  |   |  |   |  |
| 22b. SIGNATURE<br><b>David A Foley MD</b>  |  |  |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>        |  | 22c. DATE SIGNED<br><b>2/26/82</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>DAVID A FOLEY MD</b>   |  |  |  | 22e. ADDRESS<br><b>Johns Hopkins Hospital</b>   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY) <b>BURIAL</b>   |  | 23b. DATE<br><b>FEB. 28, 1982</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>MIKRO KODESH-BETH ISRAEL</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>BALTIMORE MARYLAND</b>   |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>SOL LEVINSON &amp; BROS., INC.</b><br><b>6010 REISTERSTOWN RD. BALTO., MD 21215</b>   |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>MAR 4 1982</b>  |  |   |  |
|  |  |  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Charles J. [Signature]</b>   |  |   |  |

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BALTIMORE, MARYLAND 21201  
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  | REG. NO. 82 04087   |  |  |  |
|---|--|---|--|---|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT)<br>ELIZABETH M. PEACE  |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>02 07 82  |  |  |  |
| 3. SEX<br>FEMALE  |  |   |  | 2b. HOUR<br>250 AM  |  |  |  |
| 4. RACE<br>Black  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>1 29 09  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>73   |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>PA   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE City MD.   |  |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Provident Hospital |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13a. STATE<br>Md.   |  |   |  | 13b. COUNTY   |  | 13c. CITY OR TOWN<br>Baltimore   |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>William C. Peace   |  |   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Iola Morgan   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No  |  |   |  | 16b. SOCIAL SECURITY NO.<br>N/A   |  | 17. INFORMANT ADDRESS<br>Doris E. Hurley 3233 Presstman St.  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 5070 SEPTICEMIA, STROKE<br>DUE TO, OR AS A CONSEQUENCE OF (b) ASPIRATION PNEUMONIA<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>DUE TO, OR AS A CONSEQUENCE OF (c)<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) |  |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from FEB 3RD 19 82, to FEB 7TH 19 82, that (I) (we) last saw the deceased alive on 2-7-19 82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |   |  |   |  |  |  |
| 22b. SIGNATURE<br>Ben Magnus-Lawson MD  |  |   |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>        |  | 22c. DATE SIGNED<br>2-7-82   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>BEN MAGNUS-LAWSON MD   |  |   |  | 22e. ADDRESS<br>PROVIDENT HOSPITAL BALTIMORE  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial   |  | 23b. DATE<br>2/13/82  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>King Mem. Park  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore Co. MD   |  |
| 24. FUNERAL DIRECTOR NAME<br>Wm. C. March F/H 1101 E. North Ave.  |  |   |  | 25. DATE REC'D. BY REGISTRAR<br>FEB 8 1982  |  |  |  |



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PW 3. RETAIN PAGE 5 FOR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 10 DAYS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

|   |  |                  |                 |  |  |  |  |   |                     |  |  |   |  |  |   |    |  |   |  |  |
|---|--|------------------|-----------------|--|--|--|--|---|---------------------|--|--|---|--|--|---|----|--|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  |                  | FIRST<br>CALVIN |  |  | MIDDLE<br>L.                                     |  |   | LAST<br>PEACOCK, JR |  |  | 2a. DATE KNOWN<br>OF DEATH  |  |  | ESTIMATED<br><input checked="" type="checkbox"/> 2 27 19 82 |    |  | 2b. HOUR<br>M<br>2:43                           |  |  |
| 3. SEX<br>male  |  | 4. RACE<br>black |                 | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>3 19 57  |  | 6. AGE (IN YEARS<br>LAST BIRTHDAY)<br>24 YRS.    |  | IF UNDER 1 YR.<br>MONTHS DAYS   |                     | IF UNDER 24 HRS.<br>HOURS MIN                          |  | 7c. DATE<br>PRONOUNCED<br>DEAD  |  |  | MONTH DAY YEAR<br>2 27 19 82                                |    |  | 2d. HOUR<br>2:43                                |  |  |
| 7a. BIRTHPLACE (STATE OR<br>FOREIGN COUNTRY)<br>BALTO., Md.   |  |                  |                 | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  |  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                     |  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City                              |  |  |   | PM |  |   |  |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore  |  |                  |                 | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>auto/2000 N. Bentalou Street |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK<br>FOR MOST OF WORKING LIFE)<br>PAINTER   |                     |  |  | 12b. KIND OF BUSINESS<br>OR INDUSTRY<br>Vending                                     |  |  |   |    |  |   |  |  |
| 13a. STATE<br>Md.   |  |                  |                 | 13b. COUNTY  |  | 13c. CITY OR TOWN<br>BALTO                       |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |                     | 13e. STREET ADDRESS<br>1115 Myrtle Ave                 |  |   |  |  |   |    |  |   |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>CALVIN L. Peacock Sr.   |  |                  |                 | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Josephine Johnson   |  |  |  |   |                     |  |  |   |  |  |   |    |  |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br>No   |  |                  |                 | 16b. SOCIAL SECURITY NO.   |  |  |  | 17. INFORMANT<br>ADDRESS<br>Regina Edwards 438 Oxford Ct.   |                     |  |  |   |  |  |   |    |  |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>9654 IMMEDIATE CAUSE (a) Gunshot wound of neck WEAPON: Unspecified<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which<br>gave rise to immediate<br>cause (a) stating the under-<br>lying cause last.<br>(b)<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)  |  |                  |                 |  |  |  |  |   |                     |  |  |   |  |  |   |    |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1  |  |                  |                 |  |  |  |  |   |                     |  |  |   |  |  |   |    |  |   |  |  |
| 19a. DATE OF OPERATION  |  |                  |                 | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  |  |  |   |                     |  |  | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |   |    |  |   |  |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR<br>CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |  |                  |                 | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>? P.M. 2/27 19 82   |  |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)<br>found shot in automobile   |                     |  |  |   |  |  |   |    |  |   |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/><br>AT WORK AT WORK   |  |                  |                 | 21e. PLACE OF INJURY (AT HOME,<br>STREET, FACTORY, FARM, ETC.)<br>auto in the  |  |  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br>2000B1k N. Bentalou Street, Balto City, MD   |                     |  |  |   |  |  |   |    |  |   |  |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion<br>death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |                  |                 |  |  |  |  |   |                     |  |  |   |  |  |   |    |  |   |  |  |
| ACTUAL<br>SIGNATURE<br>H. Snaw  |  |                  |                 | TITLE (SPECIFY)<br>M.D. Assistant  |  |  |  | MEDICAL EXAMINER  |                     |  |  | DATE<br>SIGNED 2/28/82  |  |  |   |    |  |   |  |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)<br>Hormez R. Guard, M.D.   |  |                  |                 | ADDRESS<br>111 Penn Street, Balto., MD 21201   |  |  |  |   |                     |  |  |   |  |  |   |    |  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial  |  |                  |                 | 23b. DATE<br>3-5-82  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>MT. AUBURN |  |   |                     | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>BALTO Md |  |   |  |  |   |    |  |   |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>JAS. A. MORTON & SONS   |  |                  |                 | ADDRESS<br>1701 LAURENS  |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br>MAR 3 1982   |                     |  |  | 25b. REGISTRAR'S SIGNATURE<br>Charles J. Smith                                      |  |  |   |    |  |   |  |  |



ADDITIONAL NO. 10



DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 4 0 8 9

1. FOR  
STATE  
REGISTRAR

REG. NO.

|   |  |   |  |   |  |  |   |   |   |   |  |
|---|--|---|--|---|--|--|---|---|---|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>VIRGINIA PEARSALE</b>  |  |   | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>2-19-82</b>                     |   |  | 2b. HOUR<br><b>M</b>   |   |   |   |   |  |
| 3. SEX<br><b>FEMALE</b>   |  | 4. RACE<br><b>COL</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>MAY 30, 1897</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>83</b>                                   |   | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.<br><b>YRS.</b>   |   |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>BURNVILLE VA</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b>                  |   |   | MD.   |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>1901 N. PAYSON ST</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF LIFE)<br><b>HOME MAKER</b>  |   | 12b. KIND OF BUSINESS OR INDUSTRY   |   |   |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>MARYLAND</b>  |  |   | 13b. COUNTY<br><b>BALTIMORE</b>  |   | 13c. CITY OR TOWN<br><b>BALTIMORE</b>                        |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   | 13e. STREET ADDRESS<br><b>1901 N. PAYSON ST</b>               |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>PATRICK HENRY KNIGHT</b>   |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>MARY KATHERINE FOWKES</b>   |  |  |   |   |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>   |  |   |  | 16b. SOCIAL SECURITY NO.  |  | 17. INFORMANT<br>ADDRESS<br><b>Mrs MARY MAIDEN 1901 N. PAYSON ST</b>           |   |   |   |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>ARTERIOSCLEROTIC HEART DIS</b><br><b>4140</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>HYPERTENSION</b>   |  |   |  |   |  |  |   |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br><b>yes</b> |   |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |   |  |   |  |  |   |   |   |   |  |
| 19a. DATE OF OPERATION  |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>      |   | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                 |   |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |   |   |   |   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |   |   |   |   |  |
| 22a. I certify that (1) this hospital attended the deceased from <b>01-13-</b> 19 <b>82</b> to <b>02-19-</b> 19 <b>82</b> , that (2) we last saw the deceased alive on <b>02-16-</b> 19 <b>82</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above; (we) did not touch the body after death. |  |   |  |   |  |  |   |   |   |   |  |
| 22b. SIGNATURE<br><b>Richard F. Tyson</b>   |  |   |  |   |  | DEGREE<br><b>M.D.</b>  |   | ATTENDING MEDICAL STAFF<br>PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/> |   | 22c. DATE SIGNED<br><b>02/20/82</b>                   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Richard F. Tyson M.D.</b>   |  |   |  |   |  | 22e. ADDRESS<br><b>936 W. North Ave. Balt. Md. 21217</b>                       |   |   |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>   |  |   | 23b. DATE<br><b>2-25-82</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>MT. RAINIER CEM</b> |  | 23d. LOCATION<br>OR TOWN COUNTY STATE<br><b>BALTIMORE MD</b>                                    |   |   |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>JOSEPH L. RUGG</b>   |  |   |  |   |  | ADDRESS<br><b>2222 W. NORTH AVE</b>  |   | 25a. DATE REC'D. BY REGISTRAR<br><b>MAR 5 1982</b>  |   | 25b. REGISTRAR'S SIGNATURE<br><b>James Van Natten</b> |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



Handwritten text on lined paper, including a date "2-19-72" and a signature "John J. [illegible]". The text is mirrored across the page.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in the office of the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

1- FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 4 0 9 0

REG. NO.

|  |  |   |   |   |  |  |
|--|--|---|---|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Hester PEARSON</b>   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>February 11, 1982</b> |   | 2b. HOUR<br><b>10:48<sup>a</sup> M</b>       |  |
| 3. SEX<br><b>Female</b>  |  | 4. RACE<br><b>blacy 7</b>   |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>8/15/1898</b>  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>S. Carolina</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>MONTHS DAYS HOURS MIN.<br><b>83</b> YRS.                     |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Maryland General Hospital</b> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.                               |  |  |
| 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Retired</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY   |   |   |  |  |
| 13a. STATE<br><b>MD.</b>   |  | 13b. COUNTY<br><b>Balto.</b>  |   | 13c. CITY OR TOWN<br><b>Balto.</b>  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Julius Pearson Montgomery</b>   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Mary P Montgomery</b>   |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>no</b>  |  | 16b. SOCIAL SECURITY NO.  |   | 17. INFORMANT<br>ADDRESS<br><b>Aritter Wright 1710 Presbury ST.</b>                             |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Arrhythmia</b><br><b>4100</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>Myocardial Infarction</b><br>(c) <b>Coronary artery disease</b>   |  |   |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>Hypertension; History of complete heart block with Pacemaker, inserted, 1974</b>  |  |   |   |   |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  |  |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |   |   |   |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>February 8</b> , 19 <b>82</b> , to <b>February 11</b> 19 <b>82</b> , that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on <b>February 11</b> , 19 <b>82</b> , and that in (no) (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) (not) view the body after death. |  |   |   |   |  |  |
| 22b. SIGNATURE<br><b>Dr. Bartholomew MD</b>  |  |   |   | 22c. DATE SIGNED<br><b>2/11/82</b>  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>John Bartholomew, M.D.</b>   |  |   |   | 22e. ADDRESS<br><b>c/o Maryland General Hospital</b>  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(b) <b>Burial</b>   |  | 23b. DATE<br><b>2/16/82</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Cedar Hill Cem.</b>                                    |  |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Balto. A.S. Md.</b>   |  |   |   |   |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Chas A. Rice FSPA 1300 Eutaw Pl.</b>  |  |   |   | 25a. DATE REC'D. BY REGISTRAR<br><b>FEB 17 1982</b>   |  |  |
| 25b. REGISTRAR'S SIGNATURE<br><b>James J. [Signature]</b>  |  |   |   |   |  |  |

U.S. A. Rice 1900

FEB 17 1902

John H. Rice, M.D., St. Mary's Hospital

St. Mary's

St. Mary's

February 11

February 11

February 11

St. Mary's

History of complaint: heart block with tremor, 1901

General history

General history

General history

General history

General history

General history

General history

General history

General history

General history

General history

General history

General history

General history

General history

General history

General history

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PW 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED IN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |                  |   |  |   |                                |   |  |   |  | REG. NO. 3 2 0 4 0 9 1                            |  |
|--|------------------|---|--|---|--------------------------------|---|--|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br>Thornwell Peoples   |                  |   |  |   |                                | 2a. DATE KNOWN OF DEATH<br>ESTIMATED <input checked="" type="checkbox"/> 2 28 19 82             |  | 2b. HOUR<br>M   |  |   |  |
| 3. SEX<br>Male   | 4. RACE<br>Black | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>6 15 1900   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>81 YRS. | IF UNDER 1 YR.<br>MONTHS DAYS   | IF UNDER 24 HRS.<br>HOURS MIN. | 2c. DATE PRONOUNCED DEAD<br>MONTH DAY YEAR<br>3 2 19 82   |  | 2d. HOUR<br>P 21 M  |  |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>S.C.  |                  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City, MD.                                     |  |   |  |   |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore   |                  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>1130 N. Fulton Avenue |  |   |                                | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                                   |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |   |  |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |                  |   |  |   |                                |   |  |   |  |   |  |
| 13a. STATE<br>Md.  |                  | 13b. COUNTY   |  | 13c. CITY OR TOWN<br>BALTO  |                                | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br>1130 N. Fulton Ave.  |  |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Ned Peoples  |                  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Eliza Peoples  |                                |   |  |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br>No  |                  | (IF YES, GIVE WAR OR DATES)   |  | 16b. SOCIAL SECURITY NO.<br>212-09-6258   |                                | 17. INFORMANT ADDRESS<br>Mrs. Marnedith Jackson 414 E. Lorraine                                 |  |   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Arteriosclerotic Cardiovascular Disease</u><br>4292<br>(b) _____<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.  |                  |   |  |   |                                |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH      |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).  |                  |   |  |   |                                |   |  |   |  |   |  |
| 19a. DATE OF OPERATION   |                  |   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |                                |   |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |   |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |                  |   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |                                | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)                   |  |   |  |   |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |                  |   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)   |                                | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |   |  |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |                  |   |  |   |                                |   |  |   |  |   |  |
| ACTUAL SIGNATURE<br>Virginia L. Dolan  |                  |   |  | TITLE (SPECIFY)<br>M.D. Assistant   |                                |   |  | DATE SIGNED<br>3-3-82   |  |   |  |
| EXAMINER'S NAME (TYPE OR PRINT)<br>Virginia L. Dolan, M.D.   |                  |   |  | ADDRESS<br>111 Penn Street  |                                |   |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial  |                  | 23b. DATE<br>3/5/82   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>King Mem PK.  |                                |   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Randalls Town Md.                     |  |   |  |
| 24. FUNERAL DIRECTOR NAME<br>JAS. A. MORGAN  |                  |   |  | ADDRESS<br>1701 LAURENS   |                                |   |  | 25a. DATE REC'D. BY REGISTRAR<br>MAR 5 1982   |  | 25b. REGISTRAR'S SIGNATURE<br>Frances Jean Mathen |  |

RECEIVED  
JAN 10 1964

Mr.  
Mrs.  
Mr.

Dr.  
Mr.  
Mrs.

Mr.  
Mrs.  
Mr.

2/2/82  
2/2/82  
2/2/82

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 12 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| FOR<br>1. STATE<br>REGISTRAR  |  |   |  | DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  | 8 2 0 4 0 9 2<br>REG. NO.  |  |   |  |
|---|--|---|--|---|--|---|--|--|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>MARGARET NMI PERKINS</b>   |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>2-28-82</b>  |  |   |  | 2b. HOUR<br><b>120 P M</b>   |  |   |  |
| 3. SEX<br><b>FEMALE</b>   |  | 4. RACE<br><b>BLACK</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>7-29-24</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>57</b> YRS.   |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.  |  |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>USA MD</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY MD.</b>                               |  |  |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>UNIV. OF MD. HOSPITAL</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>ANEMPLOYED</b>           |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |   |  |
| 13a. STATE<br><b>MD.</b>  |  | 13b. COUNTY   |  | 13c. CITY OR TOWN<br><b>BALTIMORE</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>202 N. FREMONT AVE 21201</b>   |  |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>CHARLES MAXIE</b>  |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>ARNETTA BRAXTON</b>   |  |   |  |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>UNKNOWN</b>  |  |   |  | 16b. SOCIAL SECURITY NO.<br><b>224-16-5091</b>  |  | 17. INFORMANT<br><b>PATIENT CHART</b>   |  |  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARDIO-PULMONARY ARREST</b><br><b>5570</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>MULTIPLE ORGAN FAILURE</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>SEPSIS</b> |  |   |  |   |  |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>1/2 HOUR</b><br><b>2 WEEKS</b><br><b>3 WEEKS</b> |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>CHRONIC RENAL FAILURE, HEPATIC FAILURE</b>  |  |   |  |   |  |   |  |  |  |   |  |
| 19a. DATE OF OPERATION<br><b>1-30-82</b>  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>NECROTIC SMALL BOWEL, PERITONITIS</b>  |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |  |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>1-29</b> , 19 <b>82</b> , to <b>2-28</b> , 19 <b>82</b> , that (we) lost saw the deceased alive on <b>2-28</b> , 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (we) (did) (did not) view the body after death.  |  |   |  |   |  |   |  |  |  |   |  |
| 22b. SIGNATURE<br><b>Lauren Ann Schnaper MD</b>   |  |   |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>        |  |   |  | 22c. DATE SIGNED<br><b>2-28-82</b>   |  |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>LAUREN ANN SCHNAPER</b>   |  |   |  | 22e. ADDRESS<br><b>UNIV. OF MD. HOSPITAL BALTO, MD. 21201</b>   |  |   |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>B</b>  |  | 23b. DATE<br><b>3/4/82</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Ym Cndmoke</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE  |  |  |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Joseph C Russ</b>  |  |   |  | ADDRESS<br><b>2222 W. North</b>   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>MAR 5 1982</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>John V. [Signature]</b>   |  |   |  |



1. 10/11/61

for 10/11/61



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or entombment.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified immediately.

FOR  
1- STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

B 2 0 4 0 9 3

REG. NO.

|  |   |  |   |   |   |
|--|---|--|---|---|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Clarence Perrin</b>   |   |  | 2a. DATE OF DEATH<br>MONTH <b>02</b> DAY <b>13</b> YEAR <b>82</b>                       |   | 2b. HOUR<br><b>6:20 PM</b>  |
| 3. SEX<br><b>male</b>  | 4. RACE<br><b>negro id</b>  | 5. DATE OF BIRTH<br>MONTH <b>08</b> DAY <b>04</b> YEAR <b>06</b>   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>75</b> YRS.   | IF UNDER 1 YEAR<br>MONTHS <b>04</b> DAYS <b>04</b> HOURS <b>20</b> MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>S.C.</b>   | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. <b>BALTIMORE CITY</b> OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.                        |   |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Balt. City Hosp Chronic Care Facility</b> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)                        |   | 12b. KIND OF BUSINESS OR INDUSTRY                                       |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE <b>MD</b> |   | 13b. COUNTY  | 13c. CITY OR TOWN<br><b>Baltimore</b>   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS<br><b>1907 W. Fayette St</b>                        |
| 14. FATHER'S NAME<br>FIRST <b>unknown</b> MIDDLE <b>unknown</b> LAST <b>unknown</b>                                  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>Bessie</b> MIDDLE <b>Gaston</b> LAST <b>Gaston</b> |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>                                    |   | 16b. SOCIAL SECURITY NO.<br><b>216-09-0584</b>   |   | 17. INFORMANT<br>ADDRESS<br><b>Beatrice Harger 2483 Perring Manor Rd.</b>                       |   |

|  |  |  |
|--|--|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiac Arrest</b><br><b>4960</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Respiratory Arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>COPD</b> |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br><b>45 Min</b> |
|--|--|--|

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)

|   |  |  |  |  |   |
|---|--|--|--|--|---|
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. <b>19</b>      |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)       |   |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>2/12</b> , 19 <b>82</b> , to <b>2/13</b> , 19 <b>82</b> , that (I) (we) lost<br>saw the deceased alive on <b>2/13/82</b> , 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |   |
| 22b. SIGNATURE<br><b>Valerie Brachet</b>  |  | DEGREE<br><b>MD</b>  |  | 22c. DATE SIGNED<br><b>2/13/82</b>   |   |
| 22b. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Valerie Brachet</b>   |  | 22e. ADDRESS<br><b>Baltimore City Hosp.</b>                            |  |  |   |

|  |                             |  |  |
|--|-----------------------------|--|--|
| 23a. BURIAL, CREMATION OR REMOVAL<br><b>Burial</b> | 23b. DATE<br><b>2/19/82</b> | 23c. NAME OF CEMETERY OR CREMATORY<br><b>King Memorial Pk.</b> | 23d. LOCATION<br>CITY OR TOWN <b>Baltimore</b> COUNTY <b>Co.</b> STATE <b>MD</b> |
| 24. FUNERAL DIRECTOR<br><b>Wm. C. March F/H</b>    |                             | ADDRESS<br><b>1101 E. North Ave.</b>                           | 25a. DATE REC'D. BY REGISTRAR<br><b>FEB 16 1982</b>                              |
|  |                             | 25b. REGISTRAR'S SIGNATURE<br><b>James J. [Signature]</b>      |  |



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DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 4 0 9 4

REG. NO.

1- FOR  
STATE  
REGISTRAR

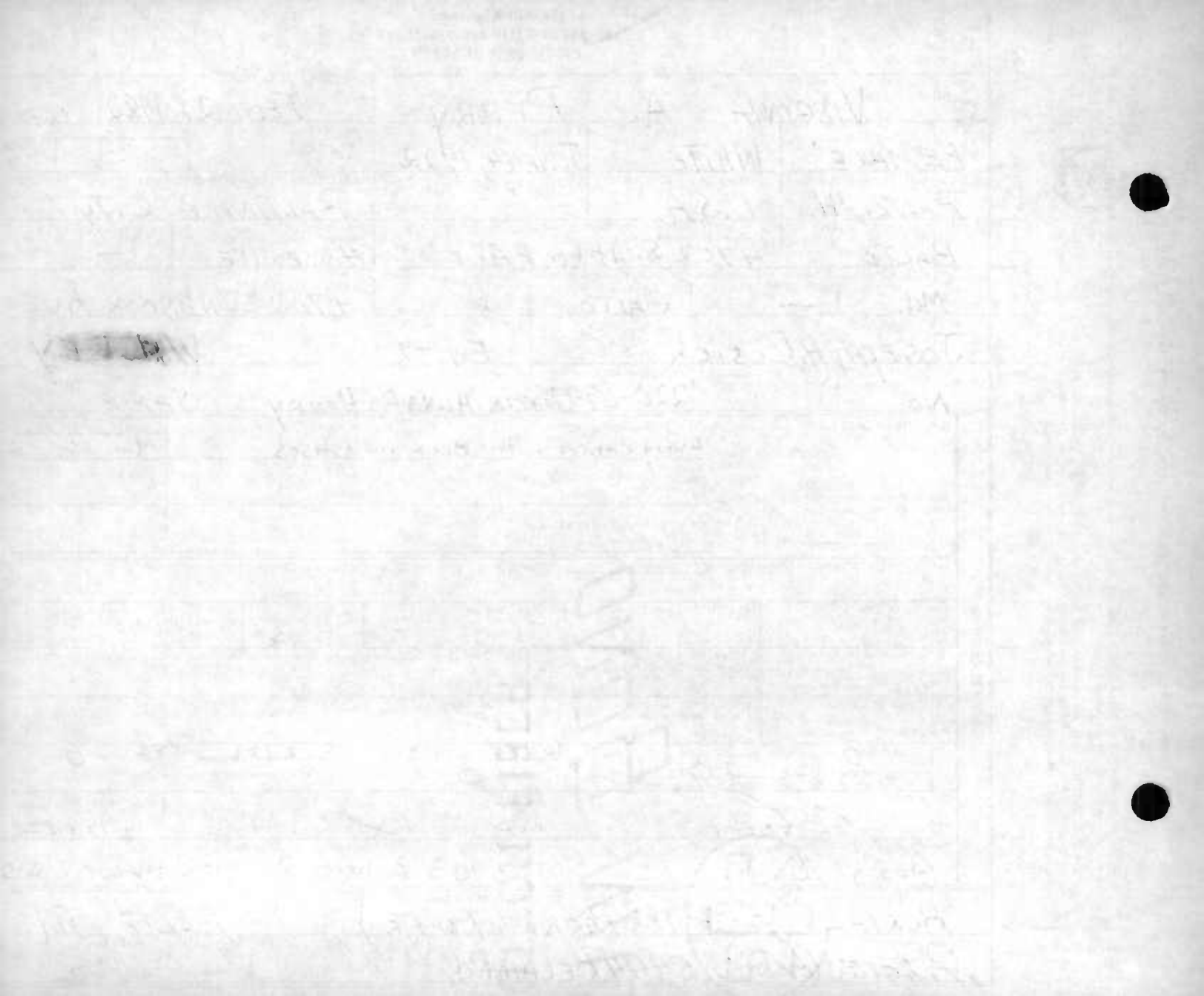
|   |        |   |        |  |                  |   |       |                                  |      |         |  |
|---|--------|---|--------|--|------------------|---|-------|----------------------------------|------|---------|--|
| 1 DECEASED NAME<br>(TYPE OR PRINT)                                  |        | FIRST   | MIDDLE | LAST   | 2a DATE OF DEATH |   | MONTH | DAY                              | YEAR | 2b HOUR |  |
| VIRGINIA A. PERRY   |        |   |        |  | FEB. 21, 1982    |   |       |                                  |      | 11 PM   |  |
| 3 SEX   | 4 RACE | 5 DATE OF BIRTH   |        | 6 AGE (IN YEARS LAST BIRTHDAY)   |                  | IF UNDER 1 YEAR   |       | IF UNDER 24 HRS                  |      |         |  |
| FEMALE  | WHITE  | JUNE 14, 1922   |        | 59   |                  | MONTHS  |       | DAYS                             |      | HOURS   |  |
| 7a BIRTHPLACE (STATE OR FOREIGN)                                    |        | 7b CITIZEN OF WHAT COUNTRY?   |        | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                  | 9 BALTIMORE CITY OR COUNTY OF DEATH                                 |       |                                  |      |         |  |
| BALTO. MD.  |        | U.S.A.  |        |  |                  | BALTIMORE CITY MD.  |       |                                  |      |         |  |
| 10 CITY OR TOWN OF DEATH  |        | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |        |  |                  | 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)     |       | 12b KIND OF BUSINESS OR INDUSTRY |      |         |  |
| BALTO   |        | 4702 SUNBROOK AVE   |        |  |                  | HOUSEWIFE   |       |                                  |      |         |  |
| 13a STATE   |        | 13b COUNTY  |        | 13c CITY OR TOWN   |                  | 13d INSIDE CITY LIMITS?   |       | 13e STREET ADDRESS               |      |         |  |
| Md.   |        | -   |        | BALTO.   |                  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |       | 4702 SUNBROOK AVE                |      |         |  |
| 14 FATHER'S NAME  |        |   |        | 15 MOTHER'S MAIDEN NAME  |                  |   |       |                                  |      |         |  |
| JOSEPH H. CUSICK  |        |   |        | EDITH WILLEY   |                  |   |       |                                  |      |         |  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) |        |   |        | 16b SOCIAL SECURITY NO.  |                  | 17 INFORMANT  |       | ADDRESS                          |      |         |  |
| No  |        |   |        | 220-093788   |                  | MR. ALVA B. PERRY   |       | SAME                             |      |         |  |

|   |  |  |
|---|--|--|
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) Lung cancer with Brain metastases<br>1629<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>DUE TO, OR AS A CONSEQUENCE OF |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>7 months |
|---|--|--|

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

|   |  |  |  |  |  |  |  |
|---|--|--|--|--|--|--|--|
| 19a DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a AUTOPSY?   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |  |
|   |  |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | YES <input type="checkbox"/> NO <input type="checkbox"/>       |  |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)         |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |  |  |
| 22a. I certify that (this hospital) attended the deceased from 10/26, 1981, to 2/24, 1982, that (we) lost above (we) (did) (did not) view the body after death. |  | 22b. SIGNATURE<br>George Lowe  |  | DEGREE<br>MD   |  | 22c. DATE SIGNED<br>2/24/82                                    |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  | 22e. ADDRESS   |  |  |  |  |  |
| George Lowe   |  | 3703 Belair Rd - Baltimore 21213                                       |  |  |  |  |  |

|   |  |                 |  |                                    |  |  |  |
|---|--|-----------------|--|------------------------------------|--|--|--|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) |  | 23b. DATE       |  | 23c. NAME OF CEMETERY OR CREMATORY |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE |  |
| BURIAL                                    |  | 2-26-1982       |  | PARKWOOD CEMETERY                  |  | BALTO. MD.                                 |  |
| 24. FUNERAL DIRECTOR<br>NAME              |  | ADDRESS         |  | 25a. DATE REC'D. BY REGISTRAR      |  | 25b. REGISTRAR'S SIGNATURE                 |  |
| J. Walter Conklin                         |  | 5444 BELAIR RD. |  | FEB 25 1982                        |  | James J. Martin                            |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified by page 3.

FOR  
1. STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |   |  |   |  |  |  |  |  |
|--|--|---|--|---|--|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Wilbur A. Pessagno</b>  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>02 12 82</b> |   |  | 2b. HOUR<br><b>1:33 A.M.</b>   |  |  |  |
| 3. SEX<br><b>Male</b>  |  | 4. RACE<br><b>White</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>09 17 15</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>66</b>   |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.                    |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Mercy Hospital, Baltimore, Md</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE AND POSSIBLE EMPLOYER)<br><b>Retired Jeweler</b>      |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>S &amp; N Katz</b>   |  |
| 13a. USUAL RESIDENCE (IF NOT IN SUCH FACILITY, GIVE RESIDENCE BEFORE ADMISSION)<br>STATE<br><b>Maryland</b>  |  | 13b. COUNTY<br><b>Parkville</b>   |  | 13c. CITY OR TOWN<br><b>Baltimore City</b>  |  | 13d. INSIDE CITY LIMITS?<br><b>YES</b> NO <input checked="" type="checkbox"/>        |  | 13e. STREET ADDRESS<br><b>1706 Hilyard Road</b>  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Albert L. Pessagno, Sr.</b>   |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE<br><b>Mary A. Lembach</b>  |  |  |  | 16. ADDRESS<br><b>Lembach</b>  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>218-09-6269</b>  |  | 17. INFORMANT<br><b>Mr Albert L Pessagno</b>  |  |  |  | 18. ADDRESS<br><b>Same</b>   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br><b>4100</b> IMMEDIATE CAUSE (a) <b>Acute Myocardial Infarction</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Coronary Artery Insufficiency</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Diabetes Mellitus</b><br>CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST |  |   |  |   |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>1 1/2 hrs</b> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>Diabetes Mellitus</b>  |  |   |  |   |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. <b>19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>2/11/82</b> to <b>2/12/82</b> , that (I) (we) last saw the deceased alive on <b>2/11/82</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (If we did not view the body after death, so state.)  |  |   |  |   |  |  |  |  |  |
| 22b. SIGNATURE<br><b>Neal M. Friedlander, MD</b>   |  |   |  | 22c. DATE SIGNED<br><b>2/12/82</b>  |  |  |  | 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Neal M. Friedlander</b>  |  |
| 22e. ADDRESS<br><b>Mercy Hospital, 301 St. Paul Place, Balt, MD 21202</b>  |  |   |  | 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |  |  |  |  |  |
| 23b. DATE<br><b>2/15/82</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Dulaney Valley</b>   |  |   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore, Maryland</b>             |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Leonard J Ruck Inc. Baltimore, Maryland</b>   |  |   |  | 25a. DATE RECD. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE<br><b>FEB 16 1982</b> <i>Thomas J. Smith</i>  |  |  |  |  |  |

A 21 22 23 24

opposed

A 21 22

(27)

21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60 61 62 63 64 65 66 67 68 69 70 71 72 73 74 75 76 77 78 79 80 81 82 83 84 85 86 87 88 89 90 91 92 93 94 95 96 97 98 99 100

21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60 61 62 63 64 65 66 67 68 69 70 71 72 73 74 75 76 77 78 79 80 81 82 83 84 85 86 87 88 89 90 91 92 93 94 95 96 97 98 99 100

21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60 61 62 63 64 65 66 67 68 69 70 71 72 73 74 75 76 77 78 79 80 81 82 83 84 85 86 87 88 89 90 91 92 93 94 95 96 97 98 99 100

21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60 61 62 63 64 65 66 67 68 69 70 71 72 73 74 75 76 77 78 79 80 81 82 83 84 85 86 87 88 89 90 91 92 93 94 95 96 97 98 99 100

21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60 61 62 63 64 65 66 67 68 69 70 71 72 73 74 75 76 77 78 79 80 81 82 83 84 85 86 87 88 89 90 91 92 93 94 95 96 97 98 99 100

21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60 61 62 63 64 65 66 67 68 69 70 71 72 73 74 75 76 77 78 79 80 81 82 83 84 85 86 87 88 89 90 91 92 93 94 95 96 97 98 99 100

21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60 61 62 63 64 65 66 67 68 69 70 71 72 73 74 75 76 77 78 79 80 81 82 83 84 85 86 87 88 89 90 91 92 93 94 95 96 97 98 99 100



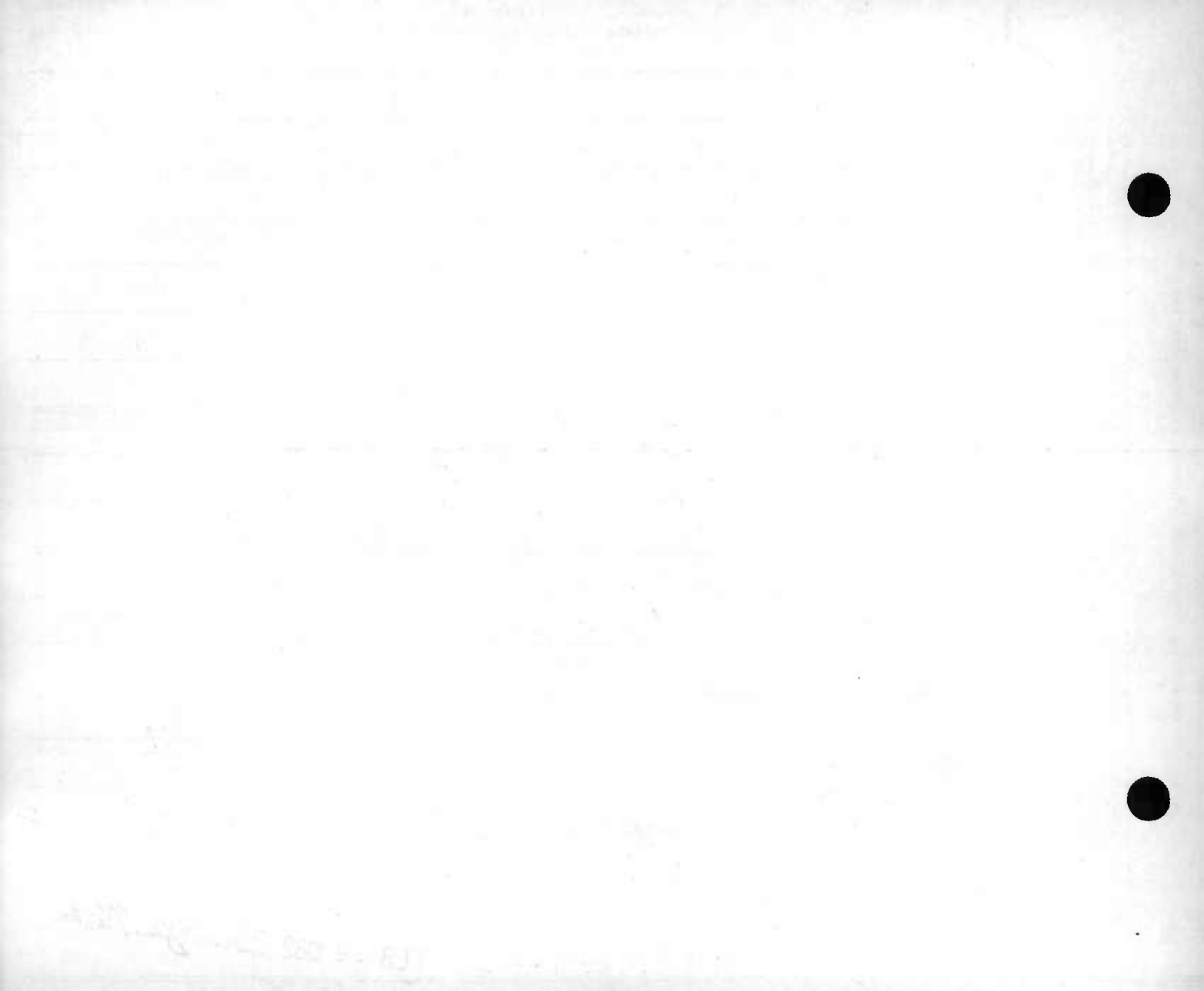
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |  | 8 2 0 4 0 9 6   |  |  |  |  |
|--|--|--|--|--|---|--|--|--|--|
| 1. FOR STATE REGISTRAR   |  |  |  |  | REG. NO.  |  |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br>Joseph F. Peters   |  |  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>February 17, 1982 |  |  |  | 2b. HOUR<br>M                                |
| 3 SEX<br>Male  |  | 4 RACE<br>Black  |  | 5 DATE OF BIRTH MONTH DAY YEAR<br>10 5 1923  |   | 6 AGE (IN YEARS LAST BIRTHDAY)<br>58 YRS   |  | 7a. IF UNDER 1 YEAR<br>MONTHS DAYS<br>7b. IF UNDER 24 HRS<br>HOURS MIN |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9 BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.  |  |  |  |
| 10 CITY OR TOWN OF DEATH<br>Baltimore  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>807 N. Appleton St. |  |  |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)   |  | 12b. KIND OF BUSINESS OR INDUSTRY                                      |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>Md   |  | 13b. COUNTY<br>Balto   |  | 13c. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |   | 13d. STREET ADDRESS<br>807 Appleton Street   |  |  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>John Peters   |  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Lena Griffin   |   |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>214-20-3027   |  | 17. INFORMANT ADDRESS<br>Dorothy Peters 1100 Penna Ave   |   |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line form (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Probable Resp. Arrest</u><br>DUE TO, OR AS A CONSEQUENCE OF (b) <u>Recurrent Ca. of Neck</u><br>DUE TO, OR AS A CONSEQUENCE OF (c) <u>Chronic Disease</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |  |  |  |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):<br><u>Sto Laryngectomy + pharyngectomy</u>  |  |  |  |  |   |  |  |  |  |
| 19a. DATE OF OPERATION<br><u>1979</u>  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><u>Cancer</u>  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |   |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |   |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>April</u> , 19 <u>79</u> , to <u>Feb</u> , 19 <u>82</u> , that (I) (we) lost saw the deceased alive on <u>Jan</u> , 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                |  |  |  |  |   |  |  |  |  |
| 22b. SIGNATURE<br><u>Thomas J. Lipman</u>  |  | 22c. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>T. J. Lipman</u>   |  | 22d. ADDRESS<br><u>U. of Md Hosp</u>   |   | 22e. DATE SIGNED<br><u>2/17/82</u>   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial  |  | 23b. DATE<br><u>2/22/82</u>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Cedar Hill Cemetery  |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><u>Anne Arundel Co. Northern</u>   |  |  |  |
| 24. FUNERAL DIRECTOR NAME<br>Wm. C. March F/H  |  |  |  | 24b. ADDRESS<br>1101 E. North Ave.   |   | 25a. DATE REC'D. BY REGISTRAR<br>FEB 19 1982   |  |  |  |





TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Items 12b, 14, 15 g565 3/3/82 gj

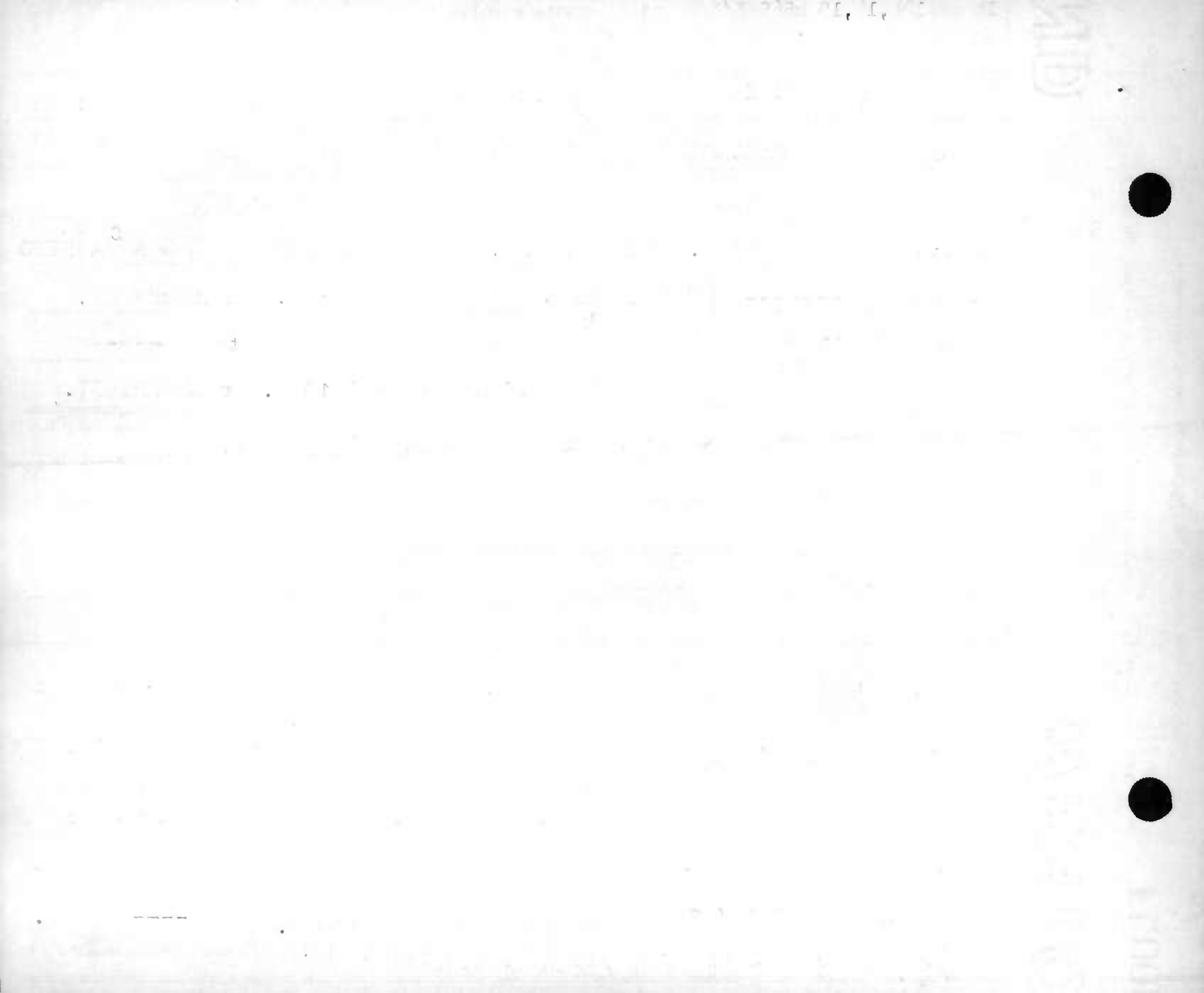
STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 4 0 9 7

FOR  
STATE  
REGISTRAR

REG. NO.

|  |  |   |  |   |  |  |  |  |  |
|--|--|---|--|---|--|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><i>Tinie</i> <b>TINIE</b>   |  | FIRST<br><i>Petr</i> <b>PETR</b>  |  | LAST<br><i>Petr</i> <b>PETR</b>   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><i>02 24 82</i>   |  | 2b. HOUR<br><i>9:15A</i>   |  |
| 3 SEX<br><i>Female</i>   |  | 4 RACE<br><b>CAUCASIAN</b>  |  | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br><i>08 13 04</i>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><i>77</i>   |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MARYLAND</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.  |  |  |  |
| 10 CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>3013 E. McELDERRY ST.</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>LABORER</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>MEATPACKING</b>  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>MARYLAND</b>  |  | 13b. COUNTY<br>-----  |  | 13c. CITY OR TOWN<br><b>BALTIMORE</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 13e. STREET ADDRESS<br><b>3013 E. McELDERRY ST.</b>  |  |
| 14 FATHER'S NAME<br>(FIRST) MIDDLE LAST<br><i>George Matthew</i> <b>GEORGE Matthew</b>   |  | 15 MOTHER'S MAIDEN NAME<br>(FIRST) MIDDLE LAST<br><i>Anna Novak</i> <b>ANNA Petr</b>  |  |   |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>212073501</b>   |  | 17. INFORMANT ADDRESS<br><b>EDWARD PETR 3013 E. McELDERRY ST.</b>   |  |  |  |  |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>1790</i> <b>Malign of uterine &amp; Metastasis</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last |  |   |  |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><i>O.H.F. - Anom.</i>  |  |   |  |   |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>12/12</i> 19 <i>78</i> , to <i>2/24</i> 19 <i>82</i> , that (I) (we) last saw the deceased alive on <i>1/26</i> 19 <i>82</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                        |  |   |  |   |  |  |  |  |  |
| 22b. SIGNATURE<br><i>Joseph B. Liberto</i>   |  | DEGREE<br><i>MD</i>   |  |   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br><i>2/24/82</i>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>JOSEPH B. LIBERTO</b>  |  | 22e. ADDRESS<br><b>3508 BAYVIEW ST Baltimore, Md 21224</b>  |  |   |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>BURIAL</b>   |  | 23b. DATE<br><b>2/27/82</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>HOLY REDEEMER</b>  |  | 23d. LOCATION<br>CITY OR TOWN<br><b>BALTO</b>  |  | COUNTY STATE<br><b>MD.</b>   |  |
| 24 FUNERAL DIRECTOR<br>NAME<br><i>Jeff Coach</i>   |  | ADDRESS<br><i>2716-18 E Monument St</i>   |  | 25a. DATE REC'D BY REGISTRAR<br><b>FEB 25 1982</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><i>Thomas J. ...</i>   |  |  |  |





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
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 IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |   |  |   |  |  |   |  |
|--|--|--|--|---|--|---|--|--|---|--|
| 1. FOR STATE REGISTRAR   |  |  |  |   | REG. NO.   |   |  |  |   |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>William C. Pfeifer, Jr.</b>   |  |  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>2 9 82</b><br>2b. HOUR<br><b>4:45 AM</b> |   |  |  |   |  |
| 3. SEX<br><b>Male</b>  |  | 4. RACE<br><b>White</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>4 28 24</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>57</b><br>YRS                                   |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.   |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Balto. City</b> MD.                        |  |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>St. Agnes Hospital</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Auto Mech.</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>O'Donnell Pontiac</b>  |   |  |
| 13a. STATE<br><b>Maryland</b>  |  |  |  |   | 13b. COUNTY<br><b>Baltimore</b>  |   | 13c. CITY OR TOWN<br><b>Baltimore</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>William C. Pfeifer, Sr.</b>   |  |  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Helen Mansperger</b>           |   |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>YES WW II</b>   |  |  |  |   | 16b. SOCIAL SECURITY NO.<br><b>217-18-5946</b>                                     |   | 17. INFORMANT<br>ADDRESS<br><b>Margaret C. Pfeifer 2019 Eagle Street 21223</b> |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiogenic Shock</b><br><b>4100</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. }<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Acute Myocardial Infarction</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |  |  |  |   |  |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____   |  |  |  |   |  |   |  |  |   |  |
| 19a. DATE OF OPERATION   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>             |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>19</b>           |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)        |  |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                     |  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>Feb. 8</b> , 19 <b>82</b> , to <b>Feb 9</b> , 19 <b>82</b> , that (I) (we) lost<br>saw the deceased alive on <b>Feb 9</b> , 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) not view the body after death.                                 |  |  |  |   |  |   |  |  |   |  |
| 22b. SIGNATURE<br><b>William C. Pfeifer, Jr.</b>   |  |  |  |   | DEGREE<br><b>M.D.</b>  |   |  | 22c. DATE SIGNED<br><b>2-9-82</b>  |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>William C. Pfeifer, Jr.</b>  |  |  |  |   | 22e. ADDRESS<br><b>900 Caton Avenue</b>  |   |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |  |  | 23b. DATE<br><b>2/12/82</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Cedar Hill Cemetery</b>                   |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Crooklyn Pk. A.A. Co. Md.</b> |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Hubbard Funeral Home, Inc.</b>  |  |  |  |   | 25a. DATE REC'D. BY REGISTRAR<br><b>FEB 11 1982</b>                                |   | 25b. REGISTRAR'S SIGNATURE<br><b>James J. Kathan</b>                           |  |   |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

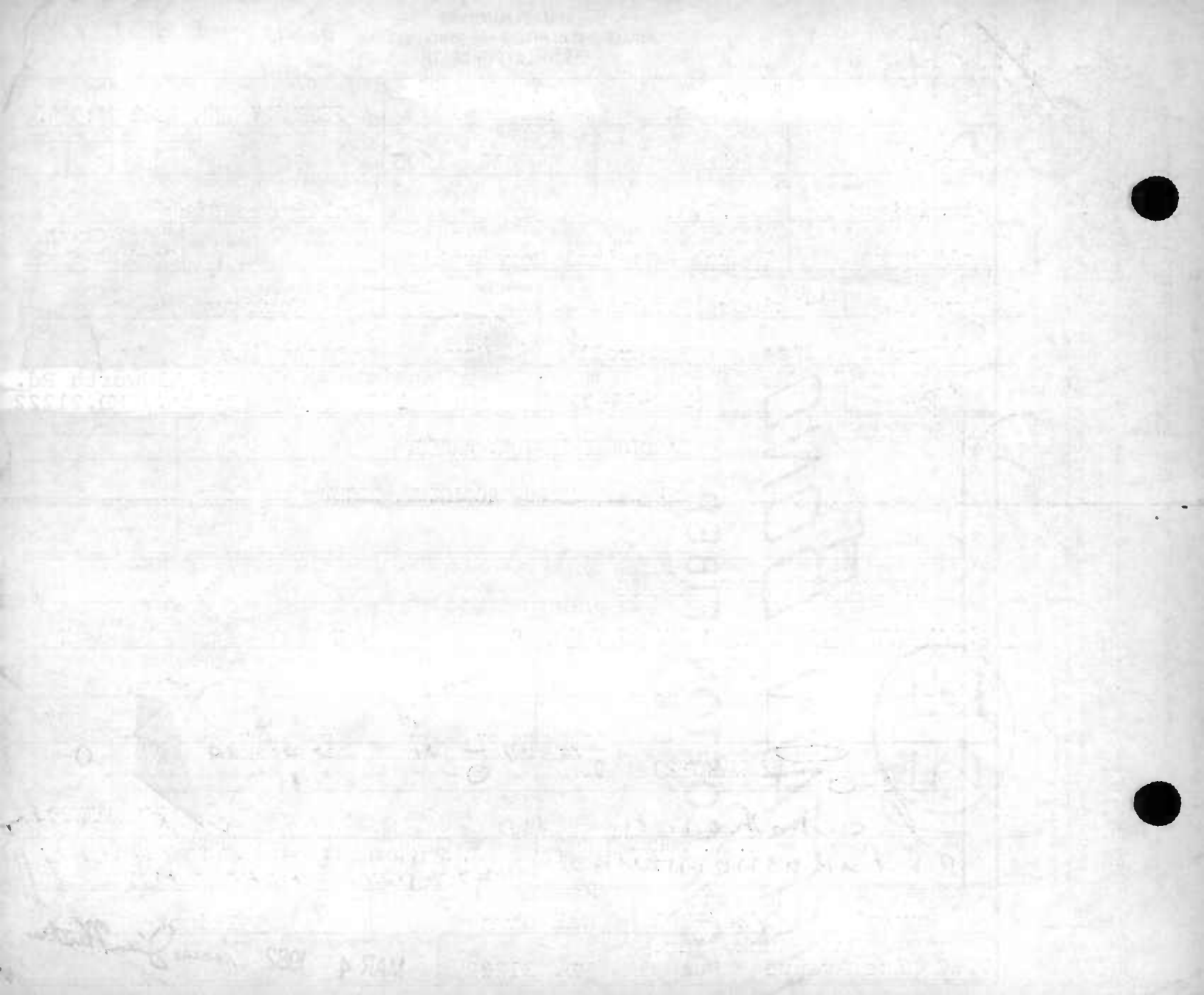
DHMH - 16 50M 1/81  
(VRA 15, 4)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 4 0 9 9

|  |  |   |  |
|--|--|---|--|
| 1. FOR STATE REGISTRAR   |  | REG. NO.  |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br><b>Frances O. Phillippi</b>  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>FEBRUARY 20, 1982</b>  |  |
| 3 SEX<br><b>Female</b>   |  | 2b. HOUR<br><b>6:00A.M.</b>   |  |
| 4 RACE<br><b>White</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>76</b> YRS.   |  |
| 5. DATE OF BIRTH MONTH DAY YEAR<br><b>4 11 1905</b>  |  | IF UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 72 HRS. HOURS MIN.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Virginia</b>   |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.   |  |
| 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Crown Cork &amp; Seal</b>   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Crown Cork &amp; Seal</b>   |  |
| 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Church Hospital Corporation</b>   |  |   |  |
| 13a. STATE<br><b>Maryland</b>  |  | 13b. CITY OR TOWN<br><b>Baltimore</b>   |  |
| 13c. CITY OR TOWN<br><b>Dundalk</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |
| 13e. STREET ADDRESS<br><b>2964 Yorkway</b>   |  |   |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>Samuel Lee Luttrell</b>  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Mary Josephine Nye</b>   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>No</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>212-18-7277</b>  |  |
| 17. INFORMANT<br><b>Dennis Hayden</b>  |  | ADDRESS<br><b>Towson Towers 21204</b>   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARDIORESPIRATORY ARREST</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>CEREBROVASCULAR ACCIDENT, RIGHT</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>HYPERTENSIVE HEART DISEASE</b>   |  |   |  |
| 19a. DATE OF OPERATION<br><b>JANUARY 25, 1982</b>  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>CARCINOMA OF THE LUNG</b>  |  |
| 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>           |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)<br><b>NO</b>  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>DECEMBER 27, 1981</b>  |  |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)<br><b>FEBRUARY 20, 1982</b>   |  |   |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, EARM, ETC.)<br><b>CHURCH HOSPITAL CORPORATION, 100 N. BROADWAY, BALTIMORE, MARYLAND</b> |  |
| 21f. LOCATION STREET CITY OR TOWN COUNTY STATE<br><b>BALTIMORE, MARYLAND</b>   |  |   |  |
| 22a. I certify that (I) this hospital attended the deceased from <b>DECEMBER 27, 1981</b> to <b>FEBRUARY 20, 1982</b> , that (I) saw the deceased alive on <b>FEBRUARY 20, 1982</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did not view the body after death.   |  |   |  |
| 22b. SIGNATURE<br><b>C. V. PURUSHOTHAMAN</b>   |  | 22c. DATE SIGNED<br><b>FEBRUARY 20, 1982</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>C. V. PURUSHOTHAMAN</b>  |  | 22e. ADDRESS<br><b>CHURCH HOSPITAL CORPORATION, 100 N. BROADWAY, BALTIMORE, MARYLAND 21231</b>  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>2/24/1982</b>   |  |
| 23c. NAME OF CEMETERY OR CREMATORY<br><b>Oak Lawn</b>  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>Baltimore</b>   |  |
| 24. FUNERAL DIRECTOR NAME<br><b>Duda-Ruck, Inc.</b>  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>MAR 4 1982</b>  |  |
| 7922 Wise Avenue Dundalk, MD. 21222  |  | 25b. REGISTRAR<br><b>James J. [Signature]</b>   |  |

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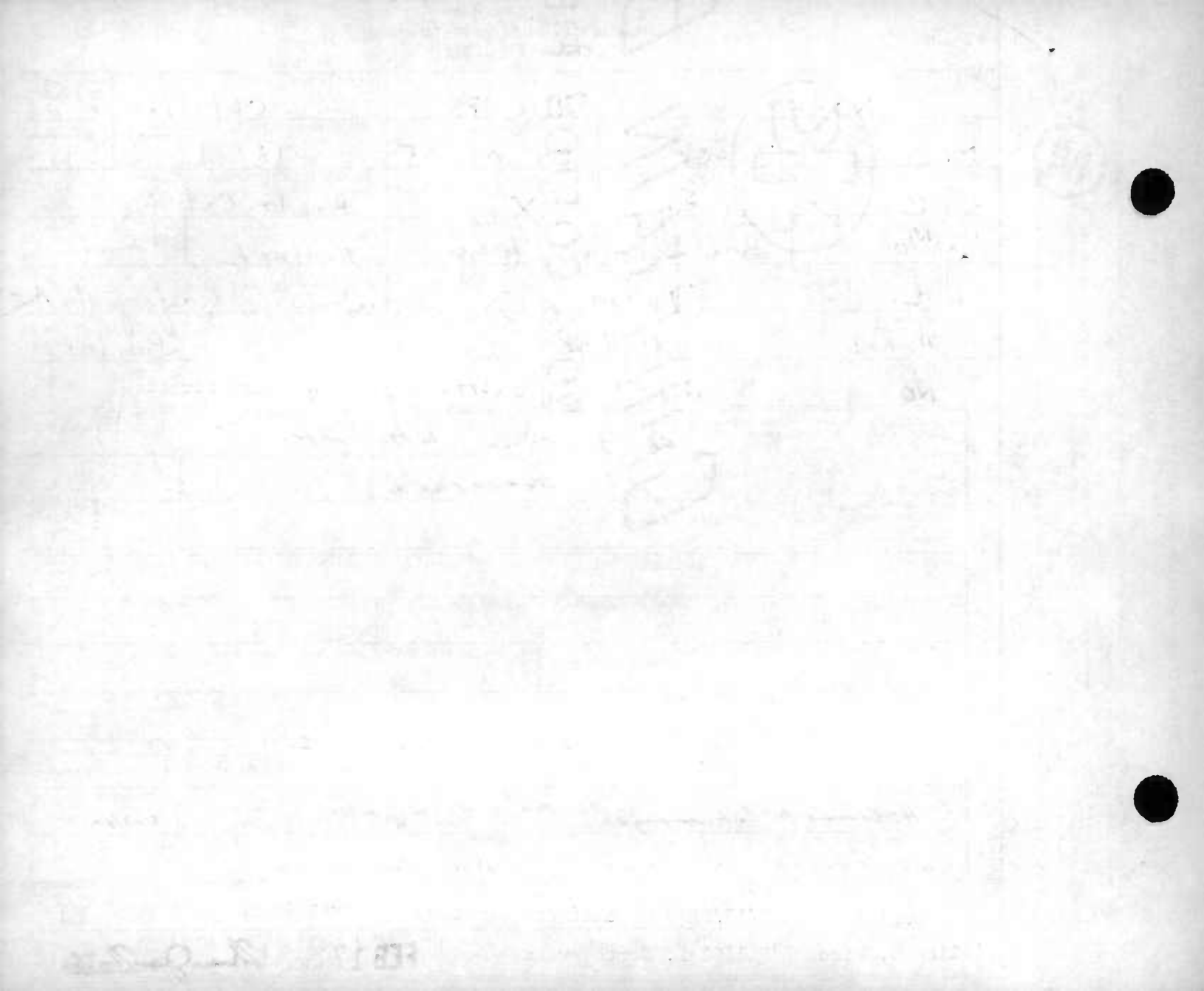




TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |                             |   |   |   |  |   |   | 8 2 0 4 1 0 0   |  |
|--|--|---|-----------------------------|---|---|---|--|---|---|---|--|
| FOR<br>1- STATE<br>REGISTRAR   |  |   |                             |   | REG. NO.  |   |  |   |   |   |  |
| 1 DECEASED NAME<br>(TYPE OR PRINT) <b>NOAH PHILLIPS</b>  |  |   |                             |   | 2a DATE OF DEATH<br>MONTH DAY YEAR <b>02/13/82</b>              |   |  |   | 2b HOUR<br><b>11 55 A M</b>               |   |  |
| 3 SEX<br><b>MALE</b>   |  | 4 RACE<br><b>BLACK</b>  |                             | 5 DATE OF BIRTH<br>MONTH DAY YEAR <b>04 03 05</b>   |   | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>76</b> YRS.  |  |   | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN. |   |  |
| 7a BIRTHPLACE<br>(COUNTRY) <b>S. C.</b>  |  | 7b CITIZEN OF WHAT COUNTRY?<br><b>U. S.</b>   |                             | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>        |   | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>Balto. City</b> MD.                                   |  |   |   |   |  |
| 10 CITY OR TOWN OF DEATH<br><b>Balto.</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>BON Secours Hosp.</b> |                             |   |   | 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Retired</b>               |  |   | 12b. KIND OF BUSINESS OR<br>INDUSTRY      |   |  |
| 13a. STATE<br><b>Md.</b>   |  | 13b. COUNTY   |                             | 13c. CITY OR TOWN<br><b>Balto.</b>  |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>2425 E. Lafayette Hc Ave.</b>                   |   |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>John Phillips</b>   |  |   |                             | 15 MOTHER'S MAIDEN NAME<br>FIRST MIDDLE<br><b>Bessie Bailey</b>   |   |   |  |   |   |   |  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>   |  | 16b SOCIAL SECURITY NO.<br><b>218-10-651</b>  |                             | 17 INFORMANT<br>ADDRESS<br><b>Oneal Phillips 946 Sheperd Street</b>   |   |   |  |   |   |   |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CA 2 colon with Liver</b><br><b>1539</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>Metastasis</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>DUE TO, OR AS A CONSEQUENCE OF (c) |  |   |                             |   |   |   |  |   |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:   |  |   |                             |   |   |   |  |   |   |   |  |
| 19a. DATE OF OPERATION   |  |   |                             | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   |                             | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART I OR PART 2)                  |  |   |   |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  |   |                             | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |   |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>1/86</b> , 19 <b>82</b> , to <b>2/13</b> , 19 <b>82</b> , that (I) (we) lost<br>saw the deceased alive on <b>1/13</b> , 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.   |  |   |                             |   |   |   |  |   |   |   |  |
| 22b. SIGNATURE<br><b>ROLEND A SABUNO</b>   |  |   |                             | DEGREE<br><b>MD</b><br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   |   |  | 22c. DATE SIGNED<br><b>2/13/82</b>  |   |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>ROLEND A SABUNO</b>  |  |   |                             | 22e. ADDRESS<br><b>Baltimore Hy</b>   |   |   |  |   |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |  |   | 23b. DATE<br><b>2/17/82</b> |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Baltimore Cemetery</b> |   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Md</b>         |   |   |  |
| 24. FUNERAL DIRECTOR<br><b>William C. March F/H 1101 E. North Avenue</b>   |  |   |                             |   |   | 25a. DATE REC'D. BY REGISTRAR<br><b>FEB 17 1982</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>James J. [Signature]</b>                 |   |   |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH-16 50M 1/81  
(VRA 15, 4)

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |  |  |   |  |  |  | REG. NO.                                     |  |
|--|--|--|--|--|--|---|--|--|--|--|--|
| 1. FOR STATE REGISTRAR   |  | 1. DECEASED NAME<br>(TYPE OR PRINT)  |  |  |  | 2a. DATE OF DEATH   |  | MONTH DAY YEAR   |  | 2b. HOUR                                     |  |
|  |  | Helen W. Piccola   |  |  |  | February 9, 1982  |  |  |  | 3:30a <sub>M</sub>                           |  |
| 3. SEX   |  | 4. RACE  |  | 5. DATE OF BIRTH   |  | 6. AGE (IN YEARS LAST BIRTHDAY)                                     |  | IF UNDER 1 YEAR  |  | IF UNDER 24 HRS                              |  |
| Female   |  | White  |  | Oct. 16, 1894  |  | 87 YRS.   |  | MONTHS DAYS  |  | HOURS MIN.                                   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |  |  |  |  |  |
| Maryland   |  | USA  |  |  |  | Baltimore City MD.  |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)       |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |  |  |
| Baltimore  |  | Maryland General Hospital  |  |  |  | Homemaker   |  | Own Home   |  |  |  |
| 13a. STATE   |  | 13b. COUNTY  |  | 13c. CITY OR TOWN  |  | 13d. INSIDE CITY LIMITS?  |  | 13e. STREET ADDRESS  |  |  |  |
| Maryland   |  |  |  | Baltimore  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 3616 Greenmount Avenue   |  |  |  |
| 14. FATHER'S NAME  |  |  |  | 15. MOTHER'S MAIDEN NAME   |  |   |  |  |  |  |  |
| Melville B. Blumenberg   |  |  |  | Lenora Landers   |  |   |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)  |  | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT  |  | ADDRESS   |  |  |  |  |  |
| No   |  | 216 10 0543  |  | Emily B. Mershon   |  | Same  |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:  |  |  |  |  |  |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| IMMEDIATE CAUSE (a) Ventricular arrhythmia   |  |  |  |  |  |   |  |  |  |  |  |
| 2765 DUE TO, OR AS A CONSEQUENCE OF (b) Hypovolemia  |  |  |  |  |  |   |  |  |  |  |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.   |  |  |  |  |  |   |  |  |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF (c)   |  |  |  |  |  |   |  |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c)  |  |  |  |  |  |   |  |  |  |  |  |
| Rectal Bleed   |  |  |  |  |  |   |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  |  | 20a. AUTOPSY?   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?   |  |  |  |
|  |  |  |  |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |   |  |  |  |  |  |
|  |  | HOUR A.M. MONTH DAY YEAR   |  |  |  |   |  |  |  |  |  |
|  |  | P.M. 19  |  |  |  |   |  |  |  |  |  |
| 21d. INJURY OCCURRED   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  | 21f. LOCATION  |  | CITY OR TOWN  |  | COUNTY   |  | STATE  |  |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |  |  |  |  |   |  |  |  |  |  |
| 22a. I certify that (this hospital) attended the deceased from February 8, 1982, to February 9, 1982, that (we) lost (saw the deceased alive on February 9, 1982, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |   |  |  |  |  |  |
| 22b. SIGNATURE   |  |  |  |  |  | DEGREE  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED                             |  |
| Walter Koppel, M.D.  |  |  |  |  |  |   |  |  |  | 2/9/82                                       |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  |  |  |  |  | 22e. ADDRESS  |  |  |  |  |  |
| Walter Koppel, M.D.  |  |  |  |  |  | C/O Maryland General Hospital                                       |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION   |  | CITY OR TOWN   |  | COUNTY STATE                                 |  |
| Burial   |  | 2/12/82  |  | Meadowridge  |  | Balto., Co.   |  |  |  | Md.  |  |
| 24. FUNERAL DIRECTOR (NAME ADDRESS)  |  |  |  |  |  | 25a. DATE REC'D. BY REGISTRAR                                       |  | 25b. REGISTRAR'S SIGNATURE   |  |  |  |
| Henry W. Jenkins & Sons Co.<br>4905 York Road Balto., Md. 21212  |  |  |  |  |  | FEB 11 1982   |  | Frances Jean Nathan  |  |  |  |

MEDICAL CERTIFICATION

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|-------|-----------------------|---------------------------|--------|--------|
| 7-304 | February 9, 1982      | Pleural                   | Wright | Wright |
|       |                       |                           | US     | US     |
|       | Baltimore City        | Maryland General Hospital |        |        |
|       | Human Resources       | Baltimore                 |        |        |
|       | 1000 Greenmount, West |                           |        |        |
|       | London                |                           |        |        |
|       |                       | Wright, E. B.             |        |        |
|       |                       | 1000 Greenmount, West     |        |        |
|       |                       |                           |        |        |

Ventricular arrhythmia

Myocardial

Acute infarct

Wright, E. B.

Wright, E. B.

Wright, E. B.

Wright, E. B.

Wright, E. B.

Wright, E. B.

Wright, E. B.

Wright, E. B.

STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE

## CERTIFICATE OF DEATH

8 2 0 4 1 0 2

FOR  
1 - STATE  
REGISTRAR

REG. NO.

|  |  |   |  |   |  |  |   |  |   |   |  |
|--|--|---|--|---|--|--|---|--|---|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Marguerite E. Pietrelli</b>   |  |   | 2a. DATE OF DEATH<br>MONTH <b>2</b> DAY <b>8</b> YEAR <b>82</b>                      |   |  | 2b. HOUR<br><b>5:20 PM</b>   |   |  |   |   |  |
| 3. SEX<br><b>F</b>   |  | 4. RACE<br><b>W</b>   |  | 5. DATE OF BIRTH<br>MONTH <b>4</b> DAY <b>11</b> YEAR <b>11</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>70</b> YRS.  |   | 6. IF UNDER 1 YEAR<br>MONTHS <b>0</b> DAYS <b>0</b>  |   | 6. IF UNDER 1 HRS<br>HOURS <b>0</b> MIN. <b>0</b> |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD                                     |   |  |   |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>3113 Fleet Street</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Clerk</b>                     |   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Pharmacy</b>  |   |  |
| 13a. STATE<br><b>Md.</b>   |  |   | 13b. COUNTY  |   | 13c. CITY OR TOWN<br><b>Baltimore</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>3113 Fleet Street</b>   |   |  |
| 14. FATHER'S NAME<br>FIRST <b>Ra</b> MIDDLE <b>Bael</b> LAST <b>Cola ngelo</b>   |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>Li</b> MIDDLE <b>berta</b> LAST <b>Schivoni</b> |   |  |  |   |  |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>  |  |   | 16b. SOCIAL SECURITY NO.<br><b>214-24-0495</b>                                       |   |  | 16c. INFORMANT<br>NAME <b>Mrs. Rose L. Mitchell</b> ADDRESS <b>620 S. Decker Ave., Baltimore Md.</b> |   |  |   |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Respiratory failure</b><br>1629<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Adenocarcinoma of Lung</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)   |  |   |  |   |  |  |   |  |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |   |  |   |  |  |   |  |   |   |  |
| 19a. DATE OF OPERATION   |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                     |   |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>                    |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |   |  |   |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)               |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |   |  |   |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>June 19 80</b> to <b>February 19 82</b> , that (I) (we) last saw the deceased alive on <b>June 20 19 82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |  |   |  |  |   |  |   |   |  |
| 22b. SIGNATURE<br><b>Allen G. Meek MD</b>  |  |   |  |   |  | DEGREE<br><b>MD</b>  |   | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |   | 22c. DATE SIGNED<br><b>2-8-82</b>                 |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>ALLEN G. MEEK</b>  |  |   |  |   |  | 22e. ADDRESS<br><b>Johns Hopkins Hospital</b>  |   |  |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |  |   | 23b. DATE<br><b>2-10-82</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Sacred Heart of Jesus Cem.</b>        |  |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Baltimore Md.</b>   |   |   |  |
| 24. FUNERAL DIRECTOR<br>NAME <b>Nicholas T. Matthews</b> ADDRESS <b>3021 Eastern Ave. Baltimore, Md.</b>   |  |   |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>FEB 17 1982</b>  |   | 25b. REGISTRAR'S SIGNATURE<br><b>Thomas J. [Signature]</b>   |   |   |  |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Physicians may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon-copiers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of this.

DHMH - 16 50M 1/81  
(VRA 15, 4)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8204103

1. FOR  
STATE  
REGISTRAR

REG. NO.

|   |   |   |   |   |  |
|---|---|---|---|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br>Grace Bozman Pilert  |   |   | 2a. DATE OF DEATH MONTH DAY YEAR<br>2 18 82                                   |   | 2b. HOUR<br>7:51 AM  |
| 3. SEX<br>Female  | 4. RACE<br>White  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>July 4, 1906  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>75 YRS.  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>6  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland   | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.                    |   |  |
| 10. CITY OR TOWN OF DEATH<br>Balto.   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Sinai Hospital |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Housewife |   | 12b. KIND OF BUSINESS OR INDUSTRY<br>Homemaker   |
| 13a. STATE<br>Md  |   | 13b. COUNTY   | 13c. CITY OR TOWN<br>Baltimore  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS<br>2284 Park Hill Avenue   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Denwood Bozman  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Iona White   |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No  |   | 16b. SOCIAL SECURITY NO.<br>215-01-9763   | 17. INFORMANT ADDRESS<br>Mr. Frank H. Pilert, 5 Firefly Cr. Cockeysville      |   |  |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Resp failure</u><br>DUE TO, OR AS A CONSEQUENCE OF (b) <u>Sepsis</u><br>DUE TO, OR AS A CONSEQUENCE OF (c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.           |   |   |   |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____  |   |   |   |   |  |
| 19a. DATE OF OPERATION  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |   | 21e. PLACE OF INJURY<br>(AT HOME STREET FACTORY OFFICE FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>1/15</u> , 19 <u>82</u> , to <u>2/18</u> , 19 <u>82</u> , that (I) (we) last saw the deceased alive on <u>2/18/82</u> , 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death. |   |   |   |   |  |
| 22b. SIGNATURE<br><u>John Gordon</u>  |   | DEGREE<br>MD  |   | 22c. DATE SIGNED<br>2/18/82   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>JOHN GORDON  |   | 22e. ADDRESS<br>SINAI HOSPITAL  |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)  |   | 23b. DATE<br>2/22/82  | 23c. NAME OF CEMETERY OR CREMATORY<br>Westview Crematory                      |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore, Maryland  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Lemmon-Mitchell-Wiedefeld, 10 W. Padonia  |   | ADDRESS<br>Rd.  |   | 25a. DATE REC'D. BY REGISTRAR<br>FEB 22 1982  |  |
|   |   |   |   | 25b. REGISTRAR'S SIGNATURE<br><u>James J. Nathan</u>  |  |

MEDICAL CERTIFICATION

29

1

1338 BP





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Possession may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 50M 1/81  
(VRA 15, 4)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 4 1 0 4

REG. NO.

|  |  |  |  |   |  |  |  |   |  |
|--|--|--|--|---|--|--|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>JOSEPH L. PLATEK</b>  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR <b>2-6-82</b>                         |   |  | 2b. HOUR <b>6:40A</b>  |  |   |  |
| 3. SEX <b>Male</b>   |  | 4. RACE <b>White</b>   |  | 5. DATE OF BIRTH <b>02 03 '20</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY) <b>62</b>  |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.   |  |
| 7. BIRTHPLACE (STATE OR FOREIGN) <b>Maryland</b>   |  | 7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b>   |  |   |  |
| 10. CITY OR TOWN OF DEATH <b>Baltimore</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Good Samaritan Hospital</b> |  |   |  | 12a. USUAL OCCUPATION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Manager</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY <b>Bank</b>   |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE <b>Md</b>   |  | 13b. COUNTY <b>Balto.</b>  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 13c. STREET ADDRESS <b>4607 Luerssen Ave. 21206</b>  |  |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST <b>Joseph Peter Platek</b>  |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST <b>Rosalie Chacka</b>   |  |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>Yes</b>  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES) <b>WW 11</b>   |  | 17. INFORMANT ADDRESS<br><b>Florence Platek 4607 Luerssen Ave.</b>  |  |  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br><b>4100x</b> IMMEDIATE CAUSE (a) <b>Myocardial Infarction</b><br>DUE TO, OR AS A CONSEQUENCE OF (b)<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last }<br>DUE TO, OR AS A CONSEQUENCE OF (c)   |  |  |  |   |  |  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (c)<br><b>Hypertension</b>  |  |  |  |   |  |  |  |   |  |
| 19a. DATE OF OPERATION <b>Jan. 80</b>  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>      |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |  |   |  |
| 22a. I certify that (I) ( <del>the hospital</del> ) attended the deceased from <b>Jan.</b> 19 <b>80</b> , to <b>2-6</b> 19 <b>82</b> , that (I) ( <del>was</del> ) lost saw the deceased alive on <b>2-6</b> 19 <b>82</b> , and that in (my) ( <del>an</del> ) opinion death occurred on the date and hour and from the causes stated above, (I) ( <del>we</del> ) ( <del>did</del> ) ( <del>do</del> ) view the body after death. |  |  |  |   |  |  |  |   |  |
| 22b. SIGNATURE<br><b>Marion C. Kowalewski</b>  |  |  | DEGREE   |   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED <b>2-6-82</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>MARION C. KOWALEWSKI</b>  |  |  | 22e. ADDRESS <b>8604 HARTFORD RD.</b>                                  |   |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>  |  | 23b. DATE <b>02/19/82</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY <b>Holy Redeemer</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE <b>Baltimore Md.</b>  |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME <b>John Crank</b> ADDRESS <b>4210 Belair Rd.</b>  |  |  |  | 25a. DATE REC'D. BY REGISTRAR <b>FEB 8 1982</b>   |  | 25b. REGISTRAR'S SIGNATURE <b>Thane J. [Signature]</b>   |  |   |  |

MEDICAL CERTIFICATION

X

X

274/BP

[illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrars, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.3  
FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 4 1 0 5

REG. NO.

|   |   |   |   |  |                                   |
|---|---|---|---|--|-----------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>Adeline N Platz</b>  |   |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>February 17, 1982</b>                                 |  | 2b. HOUR<br>M<br><b>M</b>         |
| 3. SEX<br><b>Female</b>   | 4. RACE<br><b>White</b>   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>June 3, 1905</b>   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>76</b><br>YRS. MONTHS DAYS HOURS MIN.    |                                   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.              |                                   |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Good Samaritan Hospital</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Housewife</b>            |  | 12b. KIND OF BUSINESS OR INDUSTRY |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |   |   |   |  |                                   |
| 13a. STATE<br><b>Maryland</b>   | 13b. COUNTY   | 13c. CITY OR TOWN<br><b>Baltimore</b>   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS<br><b>3014 Echodale Ave</b>                                |                                   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Walter North</b>   |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Anna E Duhamil</b>                          |  |                                   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>No</b>   |   | 16b. SOCIAL SECURITY NO.<br><b>212-10-0382</b>  |   | 17. INFORMANT ADDRESS<br><b>Mr Edwin F Platz Same</b>                          |                                   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiac arrest</b><br><b>4/292</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>A.P.E.V.D with</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>Left ventricular failure</b><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>1 hrs</b> |   |   |   |  |                                   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><b>Diabetes, gout.</b>  |   |   |   |  |                                   |
| 19a. DATE OF OPERATION  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>      |                                   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |                                   |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |                                   |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>10/16</b> , 19 <b>81</b> , to <b>10/16</b> , 19 <b>81</b> , that (I) (we) last saw the deceased alive on <b>10/16</b> , 19 <b>81</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.   |   |   |   |  |                                   |
| 22b. SIGNATURE<br><b>I.W. Fromm M.D.</b><br>c/o Dr. Benson<br>DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>  |   |   |   | 22c. DATE SIGNED<br><b>2/19/82</b>   |                                   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>I.W. Fromm M.D.</b>   |   | 22e. ADDRESS<br><b>8014 Old Harford Rd Baltimore, Maryland</b>  |   |  |                                   |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |   | 23b. DATE<br><b>2/20/82</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Parkwood</b>                          |                                   |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore, Maryland</b>  |   |   |   |  |                                   |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Leonard J Buck Inc.</b>  |   | ADDRESS<br><b>Baltimore, Maryland</b>   |   | 25a. DATE REC'D. BY REGISTRAR<br><b>FEB 19 1982</b>                            |                                   |
|   |   | 25b. REGISTRAR'S SIGNATURE<br><b>Thomas J. [Signature]</b>  |   |  |                                   |

56 \ P \ 2

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |  |   |
|--|--|--|--|--|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>BENJAMIN PLOTKIN</b>  |  |  | 2a. DATE OF DEATH MONTH <b>FEB.</b> DAY <b>7</b> YEAR <b>1982</b> 2b. HOUR <b>3:15AM</b>     |  |   |
| 3. SEX <b>MALE</b>   | 4. RACE <b>Caucasian</b>   | 5. DATE OF BIRTH MONTH <b>JUNE</b> DAY <b>5</b> YEAR <b>1905</b>   | 6. AGE (IN YEARS LAST BIRTHDAY) <b>76</b> YRS.   |  | IF UNDER 1 YEAR MONTHS <b></b> DAYS <b></b> IF UNDER 24 HRS. HOURS <b></b> MIN <b></b>                                  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Russia</b>  | 7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b> MD                                |  |   |
| 10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>KEVINDALE HEBRON GERIATRIC CENTER + HOSPITAL</b> |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>RETAIL</b>                  |  | 12b. KIND OF BUSINESS OR INDUSTRY <b>GROCERY</b>  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>MARYLAND</b>  |  | 13b. COUNTY <b>BALTIMORE</b>   | 13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13d. STREET ADDRESS <b>6500 HOPETON AVE. BALTIMORE</b>                           |   |
| 14. FATHER'S NAME FIRST <b>PHILIP</b> MIDDLE <b></b> LAST <b>PLOTKIN</b>   |  | 15. MOTHER'S MAIDEN NAME FIRST <b>FANNIE</b> MIDDLE <b></b> LAST <b>UNKNOWN</b>  |  |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>  |  | 16b. SOCIAL SECURITY NO. <b>218-32-1487</b>  |  | 17. INFORMANT ADDRESS <b>MRS. IDA PLOTKIN 6500 HOPETON AVE. BALTO., MD 21215</b> |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CA OF THE PROSTATE WITH METASTASES</b>  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>9 YRS.</b>  |
| 1850 } CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last   |  |  |  |  |   |
| DUE TO, OR AS A CONSEQUENCE OF (b) <b></b>   |  |  |  |  |   |
| DUE TO, OR AS A CONSEQUENCE OF (c) <b></b>   |  |  |  |  |   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>ASCUT WITH CHRONIC ATRIAL FIBRILLATION</b>  |  |  |  |  |   |
| 19a. DATE OF OPERATION <b></b>   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b></b>   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>           | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |   |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) <b></b>  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                   |   |
| 22a. I certify that (this hospital) attended the deceased from <b>JAN. 4</b> , 19 <b>82</b> , to <b>FEB. 7</b> , 19 <b>82</b> , that (we) last saw the deceased alive on <b>FEB. 7</b> , 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (we) (did) (not) view the body after death. |  |  |  |  |   |
| 22b. SIGNATURE <b>E. O. K. W.</b>  |  | DEGREE <b></b>   |  | 22c. DATE SIGNED <b>2/7/82</b>   |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>ESTRELLITA O. K. W., M.D.</b>   |  | 22e. ADDRESS <b>KEVINDALE HEBRON GERIATRIC CENTER + HOSPITAL</b>   |  |  |   |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>  | 23b. DATE <b>FEB. 8, 1982</b>  | 23c. NAME OF CEMETERY OR CREMATORY <b>BOBROIKSER BENEFICIAL</b>  | 23d. LOCATION CITY OR TOWN COUNTY STATE <b>CIR. ROSEDALE BALTO. MD</b>                       |  |   |
| 24. FUNERAL DIRECTOR <b>SOL LEVINSON &amp; BROS., INC.</b> NAME ADDRESS <b>6010 REISTERSTOWN RD. BALTO., MD 21215</b>  |  |  | 25a. DATE REC'D. BY REGISTRAR <b>FEB 11 1982</b>   |  | 25b. REGISTRAR'S SIGNATURE <b>Francis J. [Signature]</b>  |

STATE OF NEW YORK  
OFFICE OF THE ATTORNEY GENERAL  
ALBANY, N. Y.



1885 JUL 11 10 31 AM



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  |   |  |   |  |  |  | 8 2 0 4 1 0 7<br>REG. NO.                                     |  |                             |  |
|---|--|--|--|---|--|---|--|--|--|---|--|-----------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>ROSE</b>  |  |  |  |   | FIRST <b>REYZA</b> <b>PODOLSKAYA</b> A/K/A <b>PODOLSKY</b>           |   |  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>2 6 82</b>          |  | 2b. HOUR<br><b>6:16</b> A M |  |
| 3. SEX<br><b>OT FEMALE</b>  |  | 4. RACE<br><b>Cauc</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>MARCH 1, 1901</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>80</b> YRS  |  | IF UNDER 1 YEAR<br>MONTHS DAYS   |  | IF UNDER 24 HRS<br>HOURS MIN.                                 |  |                             |  |
| 7a. BIRTHPLACE<br>(COUNTRY)<br><b>RUSSIA</b><br><del>XXXXXX</del>   |  | 7b. CITIZENSHIP<br><b>RUSSIA</b><br><del>XXXXXX</del>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>CITY - BALTIMORE</b> MD.                             |  |  |  |   |  |                             |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>SINAI HOSP</b> |  |   |  |   |  | 12. TYPE OF WORK FOR MOST OF WORKING LIFE<br><b>HOUSEWIFE</b><br><del>XXXXXXXX</del>                                       |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>HOME</b>              |  |                             |  |
| 13a. STATE<br><b>MO</b>   |  | 13b. COUNTY  |  | 13c. CITY OR TOWN<br><b>Balto</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>5715 Park Hgts</b>   |  | 13f. APT. NO.<br><b>(21215) APT. 409</b>                      |  |                             |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Simcha Friedman</b>  |  |  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Hudel Slusky</b> |   |  |  |  |   |  |                             |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><input checked="" type="radio"/> NO   |  | 16b. SOCIAL SECURITY NO.<br><b>214-77-8895</b><br><del>XXXXXX</del>  |  | 17. INFORMANT ADDRESS<br><b>AARON FRIEDMAN 3218 NERAK RD. (21208)</b>   |  |   |  |  |  |   |  |                             |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CEREBRAL INFARCTION</b><br><b>4349</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |  |  |  |   |  |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>9 Days</b> |  |                             |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) _____  |  |  |  |   |  |   |  |  |  |   |  |                             |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |   |  |                             |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |  |   |  |  |  |   |  |                             |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |  |  |   |  |                             |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>1/27/82</b> 19____, to <b>2/6/82</b> 19____, that (I) (we) last saw the deceased alive on <b>above (we)</b> 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (we) (did) (did not) view the body after death.                             |  |  |  |   |  |   |  |  |  |   |  |                             |  |
| 22b. SIGNATURE<br><b>Gerald Gantt</b>   |  |  |  | DEGREE  |  |   |  | 22c. DATE SIGNED<br><b>2/6/82</b>  |  |   |  |                             |  |
| 22b. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>GERALD GANTT</b>  |  |  |  | 22e. ADDRESS<br><b>SINAI HOSPITAL</b>   |  |   |  |  |  |   |  |                             |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>   |  | 23b. DATE<br><b>2/7/82</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Chevra Ahavas Chesed</b>   |  |   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Randallstown, Md.</b>   |  |   |  |                             |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>SOL LEVINSON &amp; BROS.</b>   |  |  |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>FEB 11 1982</b>   |  |  |  |   |  |                             |  |
| 610 REISTERSTOWN RD. BALTIMORE, MD. (21215)   |  |  |  |   |  | 25b. REGISTRAR<br><b>James J. Nathan</b>  |  |  |  |   |  |                             |  |

ROD

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1000

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DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR1. DECEASED NAME  
(TYPE OR PRINT)

Stephen (Steven) M. Pratt Poindexter

2a. DATE KNOWN OF DEATH  
ESTIMATED  
MONTH DAY YEAR  
2 20 1982  
2b. HOUR  
M

3. SEX

Male

4. RACE

Black

5. DATE OF BIRTH  
MONTH DAY YEAR

11 3 61

6. AGE (IN YEARS)  
(LAST BIRTHDAY)  
YRS.

20

IF UNDER 1 YR.

MONTHS

DAYS

IF UNDER 24 HRS.

HOURS

MIN

7c. DATE  
PRONOUNCED  
DEAD  
MONTH DAY YEAR

2 20 1982

2d. HOUR  
P M

11:56

7a. BIRTHPLACE (STATE OR  
FOREIGN COUNTRY)

MD

7b. CITIZEN OF WHAT COUNTRY?

USA

8. MARRIED ☐ NEVER MARRIED ☒  
WIDOWED ☐ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH

Baltimore City,

MD.

10. CITY OR TOWN OF DEATH

Baltimore

11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION  
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)

700 blk. N. Fulton Avenue

12a. USUAL OCCUPATION (TYPE OF WORK  
FOR MOST OF WORKING LIFE)12b. KIND OF BUSINESS  
OR INDUSTRY

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE

MD

13b. COUNTY

13c. CITY OR TOWN

Baltimore

13d. INSIDE CITY LIMITS?

YES ☒ NO ☐

13e. STREET ADDRESS

1932 Loretta Avenue

14. FATHER'S NAME

FIRST

Clarence

MIDDLE

C.

LAST

Pratt

15. MOTHER'S MAIDEN NAME

FIRST

Earlean

MIDDLE

LAST

Poindexter

16a. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(YES, NO, OR UNKNOWN)

No

(IF YES, GIVE WAR OR DATES)

16b. SOCIAL SECURITY NO.

N/A

17. INFORMANT

ADDRESS

Clarence Pratt 1911 W. Lanvale St.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Gunshot wound of Chest

(handgun)

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATHConditions, if any, which  
gave rise to immediate  
cause (a) stating the under-  
lying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(b)  
DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?

20. AUTOPSY?

YES ☒ NO ☐

21a. EXTERNAL CAUSE WAS

UNDERLYING ☒ OR  
CONTRIBUTING ☐ CAUSE OF DEATH21b. TIME OF INJURY  
HOUR MONTH DAY YEAR

11:15 P.M. 2 20 1982

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

subject was shot

21d. INJURY OCCURRED

WHILE ☐ NOT WHILE ☒  
AT WORK AT WORK21e. PLACE OF INJURY (AT HOME,  
STREET, FACTORY, FARM, ETC.)

street

21i. LOCATION

700 blk. N. Fulton Avenue, Baltimore, Md.

22a. I certify that I took charge of the remains described above, held an

Autopsy ☒Inspection ☐Inquiry ☐

and in my opinion

death resulted from: Natural causes ☐Accident ☐Suicide ☐Homicide ☒Undetermined manner ☐ACTUAL  
SIGNATURE

Virginia L. Dolan

M.D.

TITLE (SPECIFY)  
Assistant

MEDICAL EXAMINER

DATE  
SIGNED

2-21-82

EXAMINER'S NAME  
(TYPE OR PRINT)

Virginia L. Dolan, M.D.

ADDRESS

111 Penn Street

23a. BURIAL, CREMATION, REMOVAL  
(SPECIFY)

Burial

23b. DATE

2/25/82

23c. NAME OF CEMETERY OR CREMATORY

Cedar Hill Cem.

23d. LOCATION  
CITY OR TOWN

Baltimore

COUNTY

Co.

STATE

MD

24. FUNERAL DIRECTOR

NAME

Wm. C. March F/H

ADDRESS

1101 E. North Ave.

25a. DATE REC'D. BY REGISTRAR

FEB 22 1982

25b. REGISTRAR'S SIGNATURE

Name Jan [Signature]

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1b. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

SP22 11/10/11 11:00

SP22 11/10/11 11:00

SP22 11/10/11 11:00

SP22 11/10/11 11:00



SP22 11/10/11 11:00

DHMH: 16 30M 2/80  
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  | REG. NO. 8204109  |  |   |  |
|---|--|--|--|---|--|---|--|
| 1. FOR STATE REGISTRAR  |  |  |  |   |  |   |  |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br>Bryant (Brian) D Polston  |  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>Feb 7th 1982  |  | 2b. HOUR<br>3:10 PM   |  |
| 3. SEX<br>Male  |  | 4. RACE<br>Black   |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>1 5 82   |  | 6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS<br>1 2   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MD   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD   |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Johns Hopkins Hospital |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)   |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE 13b. CITY OR TOWN 13c. STREET ADDRESS<br>MD Harford Edgewood YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> 2005 Rockwell St.  |  |  |  |   |  |   |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>Jehu Govans  |  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Beverly Polston   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>No   |  | 16b. SOCIAL SECURITY NO.<br>N/A  |  | 17. INFORMANT ADDRESS<br>Beverly Polston 2005 Rockwell St.  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Multiple organ failure<br>3202 DUE TO, OR AS A CONSEQUENCE OF (b) Group B strep meningitis<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>DUE TO, OR AS A CONSEQUENCE OF (c) |  |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)  |  |  |  |   |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from Jan 18, 1982, to Feb 7, 1982, that (I) (we) lost saw the deceased alive on Feb 7, 1982, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |  |  |   |  |   |  |
| 22b. SIGNATURE E. Shalhoub Casella MD   |  |  |  | DEGREE MD   |  | 22c. DATE SIGNED 2/7/82   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) E. Shalhoub Casella   |  |  |  | 22e. ADDRESS Johns Hopkins Hosp   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial   |  | 23b. DATE<br>2/11/82   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Mt. Calvary Cem.  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>Baltimore Co. MD   |  |
| 24. FUNERAL DIRECTOR NAME<br>Wm. C. March F/H 1101 E. North Ave.  |  |  |  | 25a. DATE REC'D. BY REGISTRAR (SEE INSTRUCTIONS) FEB 11 1982  |  |   |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| 1- FOR STATE REGISTRAR  |  | STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |   | 8 2 0 4 1 1 0  |  |
|---|--|---|---|--|--|
| 3/2/82 gj   |  | CERTIFICATE OF DEATH  |   | REG. NO.   |  |
| 1. DECEASED NAME (TYPE OR PRINT)  |  | FIRST MIDDLE LAST   |   | 2a. DATE OF DEATH MONTH DAY YEAR   |  |
| SAMUEL  |  | POOR  |   | 02 25 82   |  |
| 3. SEX  | 4. RACE  | 5. DATE OF BIRTH MONTH DAY YEAR   |   | 6. AGE (IN YEARS LAST BIRTHDAY)  |  |
| M   | B  | 12- 2 -1900   |   | 81 YRS.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   | 7b. CITIZEN OF WHAT COUNTRY?   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH   |  |
| W. VIRGINIA   | USA  |   |   | BALTIMORE CITY MD.   |  |
| 10. CITY OR TOWN OF DEATH   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) |  | 12b. KIND OF BUSINESS OR INDUSTRY            |
| Baltimore   | 306 N. Pulaski Street  |   | Ret. Longshoreman   |  |  |
| 13a. STATE  |  | 13b. COUNTY   | 13c. CITY OR TOWN   | 13d. STREET ADDRESS  |  |
| Md  |  | BALTO   |   | 306 N. Pulaski Street  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST  |   |  |  |
| Elijah  |  | Porter  |   | ATLade Mulberry  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)   |  | 16b. SOCIAL SECURITY NO.  |   | 17. INFORMANT ADDRESS  |  |
| NO  |  | 212-09-6163   |   | Luella Poor 306 N. Pulaski St.   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:   |  |   |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| IMMEDIATE CAUSE (a) 1850 CA of prostate = metastasis  |  |   |   |  |  |
| DUE TO, OR AS A CONSEQUENCE OF (b)  |  |   |   |  |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.  |  |   |   |  |  |
| DUE TO, OR AS A CONSEQUENCE OF (c)  |  |   |   |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |   |   |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>         |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |
|   |  | P.M. 19   |   |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |   | 21f. LOCATION CITY OR TOWN COUNTY STATE  |  |
|   |  |   |   | 1/12 81 03/24 82   |  |
| 22a. I certify that (I) (the hospital) attended the deceased from 2/12 19 82, to 03/24 19 82, that (I) (we) last saw the deceased alive on 2/12 19 82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death. |  |   |   |  |  |
| 22b. SIGNATURE  |  | DEGREE  |   | 22c. DATE SIGNED   |  |
| Kuang-yen Huang MD  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                  |   | 2/25/82  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  | 22e. ADDRESS  |   |  |  |
| KUANG-YEN HUANG   |  | BON SECOURS Hospital  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |  | 23b. DATE   |   | 23c. NAME OF CEMETERY OR CREMATORY   |  |
| Burial  |  | 3-1-1982  |   | ARbutus Mem PK   |  |
| 24. FUNERAL DIRECTOR NAME   |  | 24b. ADDRESS  |   | 25a. DATE REC'D. BY REGISTRAR  |  |
| Baldwin Thompson F.H.   |  | 1913 W. BALTO. ST.  |   | FEB 26 1982  |  |
|   |  |   |   | 25b. REGISTRAR'S SIGNATURE   |  |
|   |  |   |   | Thompson   |  |



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Part 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR  
1. STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 4 1 1 1

REG. NO.

|  |   |   |  |   |   |
|--|---|---|--|---|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>William H. Potts</b>  |   |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>02 27 82</b>   |   | 2b. HOUR<br><b>9.30 P.M.</b>  |
| 3. SEX<br><b>Male</b>  | 4. RACE<br><b>Black</b>   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>7 29 02</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>79</b> YRS.   | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>N.J.</b>   | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.                               |   |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Bon Secour Hospital</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)   |   | 12b. KIND OF BUSINESS OR INDUSTRY   |
| 13a. STATE<br><b>MD</b>  |   | 13b. COUNTY<br><b>Baltimore</b>   | 13c. CITY OR TOWN<br><b>Baltimore</b>  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS<br><b>2410 Liberty Heights Ave.</b>   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Thomas E. Potts</b>   |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Henrietta Johnson</b>  |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>No</b>  |   | 16b. SOCIAL SECURITY NO.<br><b>214-01-2997</b>  |  | 17. INFORMANT<br>ADDRESS<br><b>Vivian Gordon 2410 Liberty Hgts. Ave.</b>                        |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Renal failure</b><br>5860<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Senile dementia</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)   |   |   |  |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)   |   |   |  |   |   |
| 19a. DATE OF OPERATION   |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                  |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> NOT AT WORK <input type="checkbox"/>   |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>2/23</b> , 19 <b>82</b> , to <b>2/27</b> , 19 <b>82</b> , that (I) (we) lost<br>saw the deceased alive on <b>2/27</b> , 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |   |   |  |   |   |
| 22b. SIGNATURE<br><b>Kuang-yen Huang MD</b>  |   |   | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   | 22c. DATE SIGNED<br><b>2/28/82</b>  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>KUANG-YEN HUANG</b>  |   |   | 22e. ADDRESS<br><b>BON Secours Hospital</b>  |   |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |   | 23b. DATE<br><b>3/5/82</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Mt. Auburn Cem.</b>                                    |   |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore MD</b>  |   | 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Wm. C. March F/H 1101 E. North Ave.</b>  |  |   |   |
| 25a. DATE REC'D. BY REGISTRAR  |   | 25b. REGISTRAR'S SIGNATURE<br><b>James J. Nathan</b>  |  |   |   |

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR RECORDS. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH   |                      |  |   |  |   |   |   |  |  | REG. NO. 2 0 4 1 1 2 |  |
|---|----------------------|--|---|--|---|---|---|--|--|----------------------|--|
| 1. DECEASED NAME (TYPE OR PRINT) <b>Wayne B. Powell</b>   |                      |  |   |  |   | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH <b>2</b> DAY <b>8</b> YEAR <b>19 82</b>                                       |   | 2b. HOUR <b>AM</b>   |  |                      |  |
| 3. SEX <b>Male</b>  | 4. RACE <b>Black</b> | 5. DATE OF BIRTH MONTH <b>9</b> DAY <b>22</b> YEAR <b>61</b>   | 6. AGE (IN YEARS) (LAST BIRTHDAY) YRS. <b>20</b>                                | IF UNDER 1 YR. MONTHS <b>0</b> DAYS <b>0</b>   | IF UNDER 24 HRS. HOURS <b>0</b> MIN. <b>0</b>               | 7c. DATE PRONOUNCED DEAD MONTH <b>2</b> DAY <b>8</b> YEAR <b>19 82</b>  |   | 7d. HOUR <b>6:43 PM</b>  |  |                      |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MD</b>   |                      | 7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>  |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City, MD.</b>   |   |  |  |                      |  |
| 10. CITY OR TOWN OF DEATH <b>Baltimore</b>  |                      | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>1200 Blk. W. Baltimore St. (on bus)</b> |   |  |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)   |   | 12b. KIND OF BUSINESS OR INDUSTRY  |  |                      |  |
| 13a. STATE <b>MD</b>  |                      |  |   |  |   | 13b. COUNTY <b>Baltimore</b>  |   | 13c. CITY OR TOWN <b>Baltimore</b>   |  |                      |  |
| 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |                      |  |   |  |   | 13e. STREET ADDRESS <b>1935 W. Baltimore St.</b>  |   |  |  |                      |  |
| 14. FATHER'S NAME FIRST <b>Edward</b> MIDDLE <b>Powell</b> LAST <b>Powell</b>   |                      |  |   | 15. MOTHER'S MAIDEN NAME FIRST <b>Virginia</b> MIDDLE <b>Jackson</b> LAST <b>Jackson</b>   |   |   |   |  |  |                      |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>No</b>  |                      |  | 16b. SOCIAL SECURITY NO. <b>N/A</b>   |  |   | 17. INFORMANT ADDRESS <b>Virginia Powell 1935 W. Baltimore</b>  |   |  |  |                      |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br><b>9654</b> IMMEDIATE CAUSE (a) <b>Multiple gunshot wounds</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b)<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.   |                      |  |   |  |   |   |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |                      |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).   |                      |  |   |  |   |   |   |  |  |                      |  |
| 19a. DATE OF OPERATION  |                      |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                               |  |   |   |   | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |                      |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH <b>6:35 P.M. 2 8 1982</b>  |                      |  | 21b. TIME OF INJURY HOUR <b>XX</b> MONTH <b>2</b> DAY <b>8</b> YEAR <b>1982</b> |  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) <b>Subject shot</b>   |   |  |  |                      |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>   |                      |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <b>bus</b>          |  |   | 21f. LOCATION STREET <b>1200 Blk. W. Baltimore St., Balto. City, Md.</b> CITY OR TOWN <b>Baltimore</b> COUNTY <b>Baltimore</b> STATE <b>Md.</b> |   |  |  |                      |  |
| 22a. I certify that took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: <b>Natural causes</b> <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> |                      |  |   |  |   |   |   |  |  |                      |  |
| ACTUAL SIGNATURE <b>Thomas D. Smith</b>   |                      |  | TITLE (SPECIFY) <b>M.D. Deputy Chief</b>  |  |   |   | DATE SIGNED <b>2/9/82</b>   |  |  |                      |  |
| EXAMINER'S NAME (TYPE OR PRINT) <b>Thomas D. Smith, M.D.</b>  |                      |  | ADDRESS <b>111 Penn St. Balto., MD.</b>   |  |   |   |   |  |  |                      |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>   |                      |  | 23b. DATE <b>2/15/82</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY <b>King Memorial Pk.</b> |   | 23d. LOCATION CITY OR TOWN <b>Baltimore</b> COUNTY <b>Baltimore</b> STATE <b>MD</b> |  |  |                      |  |
| 24. FUNERAL DIRECTOR NAME <b>Wm. C. March F/H</b> ADDRESS <b>1101 E. North Ave.</b>   |                      |  |   |  | 25a. DATE REC'D. BY REGISTRAR <b>FEB 16 1982</b>            |   | 25b. REGISTRAR'S SIGNATURE <b>Thomas D. Smith</b>                                   |  |  |                      |  |



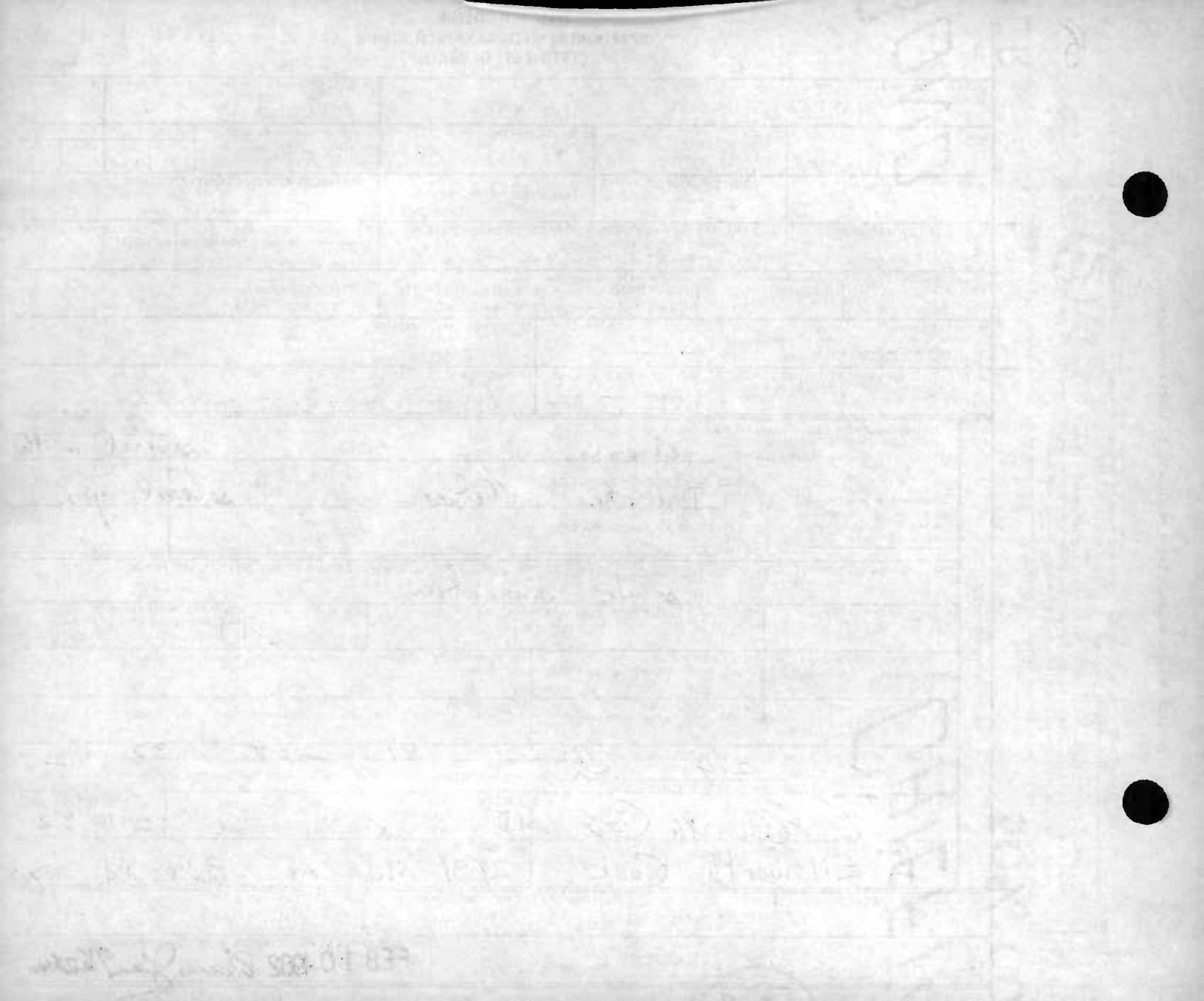
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 50M 7/77  
(VRA 15 (4))

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |   |   |  |  |   |  |  |  |
|---|--|---|---|---|--|--|---|--|--|--|
| 1. FOR<br>STATE<br>REGISTRAR  |  | REG. NO.  |   |   |  |  |   |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Johnnie Powers</b>  |  |   |   |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>February 9, 1982</b>                 |  |   | 2b. HOUR<br>M  |  |  |
| 3. SEX<br><b>Male</b>   |  | 4. RACE<br><b>Black</b>   |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>7 3 04</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>77</b> YRS.                                    |   | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>N.C.</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.                    |   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Key Circle Nursing Home</b> |   |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)                     |   | 12b. KIND OF BUSINESS OR INDUSTRY  |  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>MD</b>  |  |   | 13b. COUNTY   |   | 13c. CITY OR TOWN<br><b>Baltimore</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>1027 Cathedral St.</b>   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Quincy Powers</b>  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Leah</b>                  |   |  |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>   |  |   | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>215-07-2061</b> |   | 17. INFORMANT<br>ADDRESS<br><b>Hester Powers 1027 Cathedral St.</b>            |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Anemia</b><br><b>2500</b> DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause lost<br>(b) <b>Diabetes mellitus</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>several months</b><br><b>several yrs.</b> |  |   |   |   |  |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>senile dementia</b>   |  |   |   |   |  |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                              |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                    |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)        |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>11-2-81</b> , to <b>2-9-82</b> , that (I) (we) last saw the deceased alive on <b>2-9-82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |   |   |   |  |  |   |  |  |  |
| 22b. SIGNATURE<br><b>E. Ellsworth Cook</b>  |  |   |   |   | DEGREE<br><b>MD</b>  |  | 22c. DATE SIGNED<br><b>2.10.82</b>  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>E. Ellsworth Cook</b>   |  |   |   |   | 22e. ADDRESS<br><b>2431 Md. Ave. Balt. Md. 21218</b>                           |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>2/12/82</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Md. Nat'l Mem. Pk.</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Laurel MD</b>                       |   |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Wm. C. March F/H 1101 E. North Ave.</b>  |  |   |   |   | 25a. DATE REC'D. BY REGISTRAR<br><b>FEB 10 1982</b>                            |  |   |  |  |  |
|   |  |   |   |   | 25b. REGISTRAR'S SIGNATURE<br><b>Frances Jean Nathan</b>                       |  |   |  |  |  |

BP



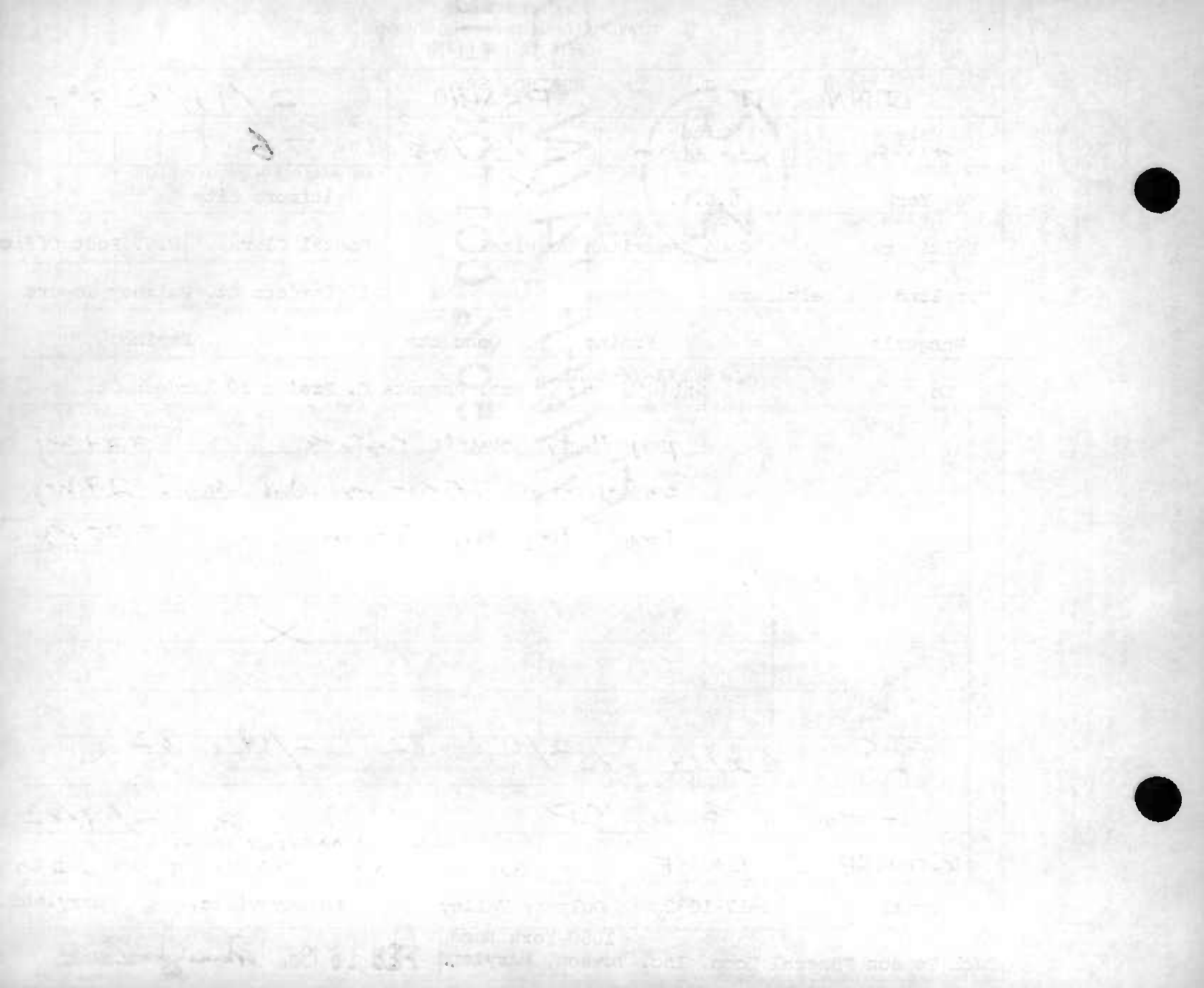


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Primary be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  |   |  |  |  |   |  | REG. NO.   |  |
|---|--|---|--|---|--|--|--|---|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) <b>JOHN J. PRAINO SR.</b>  |  |   |  |   |  | 2a. DATE OF DEATH MONTH <b>2</b> DAY <b>14</b> YEAR <b>82</b>                                |  | 2b. HOUR <b>830</b> P. M.   |  |  |  |
| 3 SEX <b>Male</b>   |  | 4. RACE <b>White</b>  |  | 5. DATE OF BIRTH MONTH <b>2</b> DAY <b>26</b> YEAR <b>05</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY) <b>76</b> YRS.   |  | IF UNDER 1 YEAR MONTHS <b></b> DAYS <b></b>   |  | IF UNDER 24 HRS. HOURS <b></b> MIN. <b></b>  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>New York</b>   |  | 7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>  |  | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.                                |  |   |  |  |  |
| 10 CITY OR TOWN OF DEATH <b>Baltimore</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Good Samaritan Hospital</b> |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Postal Clerk</b>            |  | 12b. KIND OF BUSINESS OR INDUSTRY <b>U.S. Post Office</b>   |  |  |  |
| 13a. STATE <b>Maryland</b>  |  | 13b. COUNTY <b>Baltimore</b>  |  | 13c. CITY OR TOWN <b>Towson</b>   |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS <b>10 Bardeen Ct. Dulaney Towers</b>  |  |  |  |
| 14. FATHER'S NAME FIRST <b>Pasquale</b> MIDDLE <b></b> LAST <b>Praino</b>   |  |   |  | 15. MOTHER'S MAIDEN NAME FIRST <b>Concetta</b> MIDDLE <b></b> LAST <b>Praino</b>  |  |  |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>   |  | 16b. SOCIAL SECURITY NO. <b>999-40-7483</b>   |  | 17. INFORMANT ADDRESS <b>Mrs. Assunta C. Praino 10 Bardeen Ct.</b>  |  |  |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY<br><b>7288</b> IMMEDIATE CAUSE (a) <b>papillary muscle rupture</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>extension of inferior myocardial infarction</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>longstanding hypertension</b> |  |   |  |   |  |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>= 24 hrs</b><br><b>= 29 hrs</b><br><b>= 20 yrs.</b> |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>obesity</b>   |  |   |  |   |  |  |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |  |  |  |   |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |  |  |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>2/11</b> , 19 <b>82</b> to <b>2/14</b> , 19 <b>82</b> , then (I) (we) lost <b>saw the deceased alive on 2/14 19 82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) did (did not) view the body after death.  |  |   |  |   |  |  |  |   |  |  |  |
| 22b. SIGNATURE <b>George S. Bause, MD</b>   |  | DEGREE  |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>              |  | 22c. DATE SIGNED <b>2/14/82</b>  |  |   |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>GEORGE S. BAUSE</b>  |  |   |  | 22e. ADDRESS <b>GOOD SAMARITAN HOSPITAL 601 LOCH RAVEN, BALTIMORE, MD 21239</b>   |  |  |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>   |  | 23b. DATE <b>2-17-1982</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY <b>Dulaney Valley</b>  |  | 23d. LOCATION <b>Cockeysville, COUNTY Maryland</b>   |  |   |  |  |  |
| 24. FUNERAL DIRECTOR NAME <b>Ruck Towson Funeral Home, Inc. Towson, Maryland</b>  |  |   |  | 1050 York Road  |  | 25a. DATE REC'D. BY REGISTRAR <b>FEB 16 1982</b>   |  | 25b. REGISTRAR'S SIGNATURE <b>Thomas J. [Signature]</b>   |  |  |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a post-mortem examination required.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  | REG. NO. 8 2 0 4 1 1 5   |  |   |  |
|--|--|--|--|--|--|---|--|
| 1. FOR STATE REGISTRAR   |  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR 2-14-82   |  |   |  |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST FRANCIS Edward PREISSLER  |  |  |  | 2b. HOUR 4:25 <sup>PM</sup>  |  |   |  |
| 3. SEX MALE  |  | 4. RACE CAUCASIAN  |  | 5. DATE OF BIRTH MONTH DAY YEAR 4-2-15   |  | 6. AGE (IN YEARS LAST BIRTHDAY) 66 YRS.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND   |  | 7b. CITIZEN OF WHAT COUNTRY? U.S.  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.   |  |
| 10. CITY OR TOWN OF DEATH BALTIMORE  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) UNIVERSITY HOSPITAL |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Dye Maker  |  | 12b. KIND OF BUSINESS OR INDUSTRY Steel   |  |
| 13a. STATE MARYLAND  |  | 13b. COUNTY HARFORD  |  | 13c. CITY OR TOWN WHITEHALL  |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                            |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST ANTONIO N. PREISSLER   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ALMELA BLUMERICK  |  | 13e. STREET ADDRESS 2629 BRADENBAUGH Rd.   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No   |  | 16b. SOCIAL SECURITY NO. 215-09-4100   |  | 17. INFORMANT ADDRESS Elsie L. Preissler same as above   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) respiratory failure 1629   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 days  |  |   |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) small cell carcinoma of lung 7 months   |  |  |  |  |  |   |  |
| (c) chronic obstructive airway disease years   |  |  |  |  |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I.   |  |  |  |  |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART I OR PART 2)   |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |   |  |
| 22a. I certify that (this hospital) attended the deceased from Feb. 4, 1982, to Feb 14, 1982, that (I) saw the deceased alive on Feb 14, 1982, and that in (my) opinion death occurred on the date and hour and from the causes stated above. (If not, state) view the body after death. |  |  |  |  |  |   |  |
| 22b. SIGNATURE OF PHYSICIAN Michael B. Stewart, M.D.   |  |  |  | DEGREE   |  | 22c. DATE SIGNED 2/14/82  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) MICHAEL B. STEWART, M.D.   |  |  |  | 22e. ADDRESS Baltimore Cancer Research Ctr.  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial   |  | 23b. DATE 2/19/1982  |  | 23c. NAME OF CEMETERY OR CREMATORY St. Marys Cem.  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE Pylesville Harford Md.  |  |
| 24. FUNERAL DIRECTOR NAME M. Gladden Kurtz ADDRESS Jarrettsville, Md.  |  |  |  | 25a. DATE RECD. BY REGISTRAR FEB 17 1984   |  | 25b. REGISTRAR'S SIGNATURE  |  |



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH   |  |                            |  |  |  |  |  |  |  |  |  | REG. NO. 2 0 4 1 1 6                         |  |
|---|--|----------------------------|--|--|--|--|--|--|--|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>MARIE H. PRICE</b>   |  |                            |  |  |  | 2a. DATE KNOWN OF DEATH ESTIMATED <b>2-11-82</b>                   |  | MONTH DAY YEAR   |  | 7b. HOUR <b>10:40</b>  |  |  |  |
| 3. SEX <b>female</b>  |  | 4. RACE <b>black</b>       |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR <b>2 10 80</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY) <b>2</b> YRS.                      |  | IF UNDER 1 YR. MONTHS DAYS HOURS MIN.  |  | 7c. DATE PRONOUNCED DEAD <b>2-11-82</b>  |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>   |  |                            |  | 7b. CITIZEN OF WHAT COUNTRY? <b>US</b>   |  |  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b>                         |  |  |  |
| 10. CITY OR TOWN OF DEATH <b>Baltimore</b>  |  |                            |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>South Balto. General Hospital</b> |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |  |  |
| 12a. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  | 13a. STATE <b>MARYLAND</b> |  | 13b. COUNTY  |  | 13c. CITY OR TOWN <b>BALTIMORE</b>                                 |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 13e. STREET ADDRESS <b>2622 MAISBURY CT.</b>                                       |  |  |  |
| 14. FATHER'S NAME <b>STEWART</b> MIDDLE <b>PRICE</b> LAST   |  |                            |  |  |  | 15. MOTHER'S MAIDEN NAME <b>CAROLYN</b> MIDDLE <b>WARD</b> LAST    |  |  |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)  |  |                            |  | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT <b>CAROLYN WARD</b> ADDRESS <b>2622 MAISBURY CT.</b> |  |  |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br><b>3439</b> IMMEDIATE CAUSE (a) <b>Cerebral palsy</b><br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.<br>(b) _____<br>(c) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>DUE TO, OR AS A CONSEQUENCE OF<br>DUE TO, OR AS A CONSEQUENCE OF  |  |                            |  |  |  |  |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):   |  |                            |  |  |  |  |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  |                            |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  |  |  |  |  | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |  |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |  |                            |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>  |  |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)  |  |  |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  |                            |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)  |  |  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |  |  |  |  |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |                            |  |  |  |  |  |  |  |  |  |  |  |
| ACTUAL SIGNATURE <b>Margarita A. Korell</b>   |  |                            |  | TITLE (SPECIFY) <b>Assistant</b>   |  |  |  | DATE SIGNED <b>2-11-82</b>   |  |  |  |  |  |
| EXAMINER'S NAME (TYPE OR PRINT) <b>Margarita A. Korell, M.D.</b>  |  |                            |  | ADDRESS <b>111 Penn Street</b>   |  |  |  |  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL <b>BURIAL</b>   |  |                            |  | 23b. DATE <b>2-17-82</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY <b>MT. CALVARY</b>              |  |  |  | 23d. LOCATION CITY OR TOWN <b>BALTIMORE</b> COUNTY <b>MARYLAND</b> STATE <b>MD</b> |  |  |  |
| 24. FUNERAL DIRECTOR NAME <b>E.L. PHILLIPS</b> ADDRESS <b>1721 N. MONROE ST.</b>  |  |                            |  |  |  | 25a. DATE REC'D. BY REGISTRAR <b>FEB 18 1982</b>                   |  | 25b. REGISTRAR'S SIGNATURE <b>Frances Jan Nathan</b>   |  |  |  |  |  |

1000 COMMON BIRDS

1000 COMMON BIRDS

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |   |   |  |   |
|---|--|---|---|--|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>Regina D. Price (Brown)</b>  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>2 15 1982</b>   |  | 2b. HOUR<br>M<br><b>M</b>   |
| 3. SEX<br><b>Female</b>   | 4. RACE<br><b>Black</b>  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>10 13 1891</b>   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>90</b> YRS.                                    | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Md</b>  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore city</b> MD.                    |   |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>2029 Sinclair Lane</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)                                |  | 12b. KIND OF BUSINESS OR INDUSTRY   |
| 13a. USUAL RESIDENCE<br>13a. STATE<br><b>Md</b>   | 13b. COUNTY  | 13c. CITY OR TOWN<br><b>Baltimore</b>   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS<br><b>2029 Sinclair Lane</b>                                     |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Jessie Dent</b>  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Catherine Gray Dent</b>                     |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>No</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>212-07-3613</b>  |   | 17. INFORMANT<br>ADDRESS<br><b>Mrs. Rita Hardy 2029 Sinclair Lane</b>                |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARDIO RESPIRATORY ARREST</b><br><b>4149</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>CORONARY ARTERY DISEASE</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>HYPERTENSION</b>   |  |   |   |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br><b>IMMEDIATE</b><br><b>710 years</b><br><b>710 years</b>                   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |   |   |  |   |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. <b>19</b>   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>DECEMBER</b> , 19 <b>81</b> , to <b>FEBRUARY</b> , 19 <b>82</b> , that (I) (we) lost<br>saw the deceased alive on <b>FEBRUARY 2</b> , 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above (I) (we) (did) (did not) view the body after death. |  |   |   |  |   |
| 22b. SIGNATURE<br><b>Serena Nolan MD</b>  |  | DEGREE<br><b>MD</b>   |   | 22c. DATE SIGNED   |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>SERENA NOLAN MD</b>   |  | 22e. ADDRESS<br><b>2149 KIRK AVENUE BALTIMORE 21218</b>   |   |  |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   | 23b. DATE<br><b>2/20/82</b>  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Arbutus Memorial Pk</b>  |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Arbutus MD</b>                      |   |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>William C. March F/H 1101 E. North Avenue</b>  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>FEB 16 1982</b>   |   | 25b. REGISTRAR'S SIGNATURE<br><b>Thomas J. [Signature]</b>                           |   |



| Date |  | Time |  | Location |  | Remarks |  |
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified if one is not retained by the hospital or attending physician.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  | 8 2 0 4 1 1 8  |  |  |  |
|---|--|--|--|--|--|--|--|
| 1. FOR STATE REGISTRAR  |  |  |  | REG. NO.   |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT) <b>SIDNEY A. PRICE</b>   |  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR <b>FEBRUARY 14, 1982</b>  |  | 2b. HOUR <b>2:00PM</b>   |  |
| 1. SEX <b>Male</b>  |  | 4. RACE <b>White</b>   |  | 5. DATE OF BIRTH MONTH DAY YEAR <b>Jan. 13, 1911</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY) <b>71</b> YRS.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>   |  | 7b. CITIZEN OF WHAT COUNTRY? <b>U.S.B.</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b> MD.   |  |
| 10. CITY OR TOWN OF DEATH <b>Baltimore City</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>JOHNS HOPKINS HOSPITAL</b> |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Farmer</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY <b>Farming</b>   |  |
| 13a. STATE <b>Maryland</b>  |  |  |  | 13b. COUNTY <b>Wicomico</b>  |  | 13c. CITY OR TOWN <b>Salisbury</b>   |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST <b>J. Walter Price</b>  |  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Maggie Ennis</b>   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b>   |  | 16b. SOCIAL SECURITY NO. <b>220-34-9255</b>  |  | 17. INFORMANT ADDRESS <b>June W. Price Same as 13 a,b,c,d,e</b>  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>cardiac arrest</b><br><b>1991</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>pulmonary arrest</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>sepsis</b> |  |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)<br><b>coma base 2050 clivus meningioma and hydrocephalus</b>   |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION <b>1/82</b>  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Removal of clivus tumor</b>  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USEFUL IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF DEATH HOUR A.M. MONTH DAY YEAR <b>2:00 P.M. 2/14/82</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)   |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from above, (I) (we) (did) (did not) view the body after death, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated   |  |  |  |  |  |  |  |
| 22b. SIGNATURE <b>John W. Price</b>   |  |  |  | DEGREE   |  | 22c. DATE SIGNED <b>2/14/82</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>John W. Price</b>  |  |  |  | 22e. ADDRESS <b>JOHNS HOPKINS HOSPITAL</b>   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>   |  | 23b. DATE <b>2/18/82</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY <b>Sunnyridge Cemetery</b>  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE <b>Crisfield Somerset Md.</b>  |  |
| 24. FUNERAL DIRECTOR NAME <b>Bradshaw &amp; Sons</b> ADDRESS <b>Crisfield, Md. 21817</b>  |  |  |  | 25a. DATE REC'D. BY REGISTRAR <b>FEB 19 1982</b>   |  | 25b. REGISTRAR'S SIGNATURE <b>James J. [Signature]</b>   |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  | REG. NO.   |   |
|--|--|---|--|--|---|
| 1. FOR STATE REGISTRAR   |  |   |  | 82 04119   |   |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>EUGENIA W. PUMPHREY  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>February 1, 1982      |  | 2b. HOUR<br>12:00 M   |
| 3. SEX<br>Female   | 4. RACE<br>White   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>Jan. 5, 1893  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>89 YRS.   | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.                                |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br>New York   | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.   |   |
| 10. CITY OR TOWN OF DEATH<br>Baltimore   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>418 Calvin Avenue |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Sales<br>12b. KIND OF BUSINESS OR INDUSTRY<br>Hochschild's |   |
| 13a. STATE<br>Maryland   |  |   | 13b. COUNTY  | 13c. CITY OR TOWN<br>Baltimore   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Eugene E. Wethey   |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Fanny Brown |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>No   |  | 16b. SOCIAL SECURITY NO.<br>215 10 7093   |  | 17. INFORMANT<br>ADDRESS<br>Mrs. Roselle E. Deane, Same  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Liver & Kidney Failure<br>1749<br>DUE TO, OR AS A CONSEQUENCE OF (b) Metastatic breast cancer - wide<br>DUE TO, OR AS A CONSEQUENCE OF (c) Spread<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>1 year |  |   |  |  |   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |   |  |  |   |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)  |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK<br>NOT WHILE <input type="checkbox"/> AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Spt 77</u> to <u>Dec 82</u> , that (I) (we) last saw the deceased alive on <u>Dec 22, 1981</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) saw the body after death.               |  |   |  |  |   |
| 22b. SIGNATURE<br>Robert E. Martin MD  |  |   |  | 22c. DATE SIGNED<br>2/2/82   |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Dr. Robert E. Martin, M.D.  |  |   |  | 22e. ADDRESS<br>3201 N. Charles Street, Balto., Md.  |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Cremation  |  | 23b. DATE<br>2/3/82   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Green Mount  |   |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore, Maryland  |  | 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br>Henry W. Jenkins & Sons Co.<br>4905 York Road Balto., Md. 21212   |  |  |   |
| 25a. DATE REC'D. BY REGISTRAR<br>FEB 2 1982  |  |   |  | 25b. REGISTRAR'S SIGNATURE<br>Thomas J. [Signature]  |   |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it must be completely filled in and signed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please bring the certificate to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or entombment.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH: 16 30M 2/80  
(VRA 15, 4)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 4 1 2 0

|  |  |   |   |
|--|--|---|---|
| 1. FOR STATE REGISTRAR   |  | REG. NO.  |   |
| 1. DECEASED NAME (TYPE OR PRINT)   |  | 2a. DATE OF DEATH   |   |
| FIRST MIDDLE LAST<br>Earl F. Purnell   |  | MONTH DAY YEAR HOUR<br>2 8 1982 9:37 M  |   |
| 3. SEX   | 4. RACE  | 5. DATE OF BIRTH  | 6. AGE (IN YEARS LAST BIRTHDAY)                                     |
| Male   | Black  | MONTH DAY YEAR<br>11 27 95  | 86 YRS.   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  | 7b. CITIZEN OF WHAT COUNTRY?   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |
| MD   | USA  |   | BALTIMORE CITY MD   |
| 10. CITY OR TOWN OF DEATH  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)       |
| Baltimore  | JOHNS HOPKINS HOSPITAL   |   | 12b. KIND OF BUSINESS OR INDUSTRY                                   |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |   |   |
| 13a. STATE   | 13b. COUNTY  | 13c. CITY OR TOWN   | 13d. INSIDE CITY LIMITS?  |
| MD   |  | Baltimore   | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 14. FATHER'S NAME (FIRST MIDDLE LAST)  |  | 15. MOTHER'S MAIDEN NAME (FIRST MIDDLE LAST)  |   |
| Sydney Purnell   |  | Celia Dennis  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)  |  | 16b. SOCIAL SECURITY NO.  |   |
| No   |  | 217-01-9307   |   |
| 17. INFORMANT  |  | ADDRESS   |   |
| Bessie Brown   |  | 1206 N. Eden St.  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Metastatic Prostatic Carcinoma</u><br>1850<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                        |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)  |  |   |   |
| 19a. DATE OF OPERATION   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   | 20a. AUTOPSY?   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?      |
|  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   | YES <input type="checkbox"/> NO <input type="checkbox"/>            |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                 | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>2/3/82</u> 19_____, to <u>3/8/82</u> 19_____, that (I) (we) last saw the deceased alive on <u>2/8/82</u> 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                               |  |   |   |
| 22b. SIGNATURE<br><u>John L. Niles</u>   |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>        | 22c. DATE SIGNED  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>John L. Niles</u>  |  | 22e. ADDRESS<br><u>Johns Hopkins Hospital.</u>  |   |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  | 23b. DATE  | 23c. NAME OF CEMETERY OR CREMATORY  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE                          |
| Burial   | 2/12/82  | Cedar Hill Cem.   | Baltimore CO. MD  |
| 24. FUNERAL DIRECTOR<br>NAME   |  | 25a. DATE REC'D. BY REGISTRAR   | 25b. REGISTRAR  |
| Wm. C. March F/H 1101 E. North Ave.  |  | FEB 9 1982  | Charles J. Nathan   |

MEDICAL CERTIFICATION

1001





Release Non Med Mr. Freeman

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 50M 1/81  
(VRA 15, 4)STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 4 1 2 1

REG. NO.

|   |  |   |  |   |  |   |  |  |  |  |  |                             |  |
|---|--|---|--|---|--|---|--|--|--|--|--|-----------------------------|--|
| 1. FOR<br>STATE<br>REGISTRAR  |  | 1. DECEASED NAME<br>(TYPE OR PRINT)   |  | FIRST<br>Russell  |  | MIDDLE<br>Purnell   |  | LAST<br>Purnell  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>2 12 1982 |  | 2b. HOUR<br>12 A M          |  |
| 3. SEX<br>Male  |  | 4. RACE<br>black  |  | 5. DATE OF BIRTH<br>8 <sup>TH</sup> 2 DAY 22 <sup>AR</sup>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>59 YRS   |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS  |  | 8. IF UNDER 24 HRS<br>HOURS MIN.                 |  |                             |  |
| 9. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MD  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore city MD.                                      |  |  |  |  |  |                             |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Johns Hopkins Hospital |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |  |  |  |  |                             |  |
| 13a. STATE<br>Md  |  | 13b. COUNTY   |  | 13c. CITY OR TOWN<br>Baltimore  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br>820 McDonogh St.  |  |  |  |                             |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Sidney Purnell  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Lola Fleming   |  |   |  |   |  |  |  |  |  |                             |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>Yes   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>220-14-6583  |  | 17. INFORMANT ADDRESS<br>Mildred Berry 820 McDonogh St.   |  |   |  |  |  |  |  |                             |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Acute myocardial infarction</u><br>4100<br>DUE TO, OR AS A CONSEQUENCE OF (b) <u>arteriosclerotic cardiovascular disease.</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>DUE TO, OR AS A CONSEQUENCE OF (c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>sudden</u><br><u>4 years</u> |  |   |  |   |  |   |  |  |  |  |  |                             |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: 10   |  |   |  |   |  |   |  |  |  |  |  |                             |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |  |                             |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |  |   |  |  |  |  |  |                             |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |  |  |  |  |                             |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>4/25/78</u> 19____ to <u>1/19/82</u> 19____, that (I) (we) last saw the deceased alive on <u>1/19/82</u> 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If the body was not seen after death, so state.)   |  |   |  |   |  |   |  |  |  |  |  |                             |  |
| 22b. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Wilhelm E. Baermann, M.D.  |  |   |  |   |  |   |  |  |  |  |  | 22c. DATE SIGNED<br>2/12/82 |  |
| 22d. ADDRESS<br>OPD Church Hospital Corporation<br>Baltimore, Md. 21231   |  |   |  |   |  |   |  |  |  |  |  |                             |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial  |  | 23b. DATE<br>2/16/82  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Baltimore Cem.  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore MD                                      |  |  |  |  |  |                             |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>William C. March F/H 1101 E. North Avenue   |  |   |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br>FEB 16 1982  |  | 25b. REGISTRAR'S SIGNATURE<br><i>Thomas J. North</i>   |  |  |  |                             |  |

MEDICAL CERTIFICATION

9  
9

0704 BP

arteriosclerotic cardiovascular disease  
4 years  
essential hypertension

1/1/83

1/1/83

1/1/83

1/1/83

Old Church Street 1 Corner tion  
Belmont, Va. 22111

Wilhelm E. Gernsmeier, M.D.

1/1/83

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

2 0 4 1 2 2

|   |                         |  |   |   |   |  |   |  |
|---|-------------------------|--|---|---|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Terry Neel Purvis</b>   |                         |  | 2a. DATE KNOWN OF DEATH<br>ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR<br><b>xx 2 25 19 82</b> |   |   | 2b. HOUR<br><b>M</b>   |   |  |
| 3. SEX<br><b>male</b>   | 4. RACE<br><b>white</b> | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Jan 25, 1956</b>  | 6. AGE (IN YEARS)<br>LAST BIRTHDAY<br><b>26 YRS.</b>  | IF UNDER 1 YR.<br>MONTHS DAYS HOURS MIN.  | 7c. DATE PRONOUNCED DEAD<br><b>2 26 1982</b>  | 7d. HOUR<br><b>3:14</b>  |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>  |                         | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD                               |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   |                         | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>1 West Conway St. Apt 309</b> |   |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Unemployed</b>                    |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |                         |  | 13a. STATE<br><b>Maryland</b>   |   |   | 13b. COUNTY<br><b>---</b>  |   |  |
| 13c. CITY OR TOWN<br><b>Baltimore</b>   |                         |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                 |   |   | 13e. STREET ADDRESS<br><b>1 West Conway St. Apt 309</b>  |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>George Neel Purvis</b>   |                         |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Norma D Cadue</b>   |   |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br><b>No</b>  |                         |  | 16b. SOCIAL SECURITY NO.<br><b>218-64-6915</b>  |   |   | 17. INFORMANT<br><b>Randallstown Maryland</b><br><b>G. Neel Purvis 10203 Liberty Rd. 21133</b> |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Barbiturate intoxication</b><br>9501<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>DUE TO, OR AS A CONSEQUENCE OF  |                         |  |   |   |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).   |                         |  |   |   |   |  |   |  |
| 19a. DATE OF OPERATION  |                         |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |   |   |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |                         |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>Est. 2/25/82 P.M.</b>                                     |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)<br><b>self ingested</b> |  |   |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>   |                         |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)<br><b>Home</b>                                      |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br><b>1 West Conway St. Baltimore Md.</b>           |  |   |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: <b>Natural causes</b> <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |                         |  |   |   |   |  |   |  |
| ACTUAL SIGNATURE<br><b>Hormez R. Guard</b>  |                         |  | TITLE (SPECIFY)<br>M.D. <b>Assistant</b> MEDICAL EXAMINER   |   |   |  | DATE SIGNED<br><b>2/27/82</b>   |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)<br><b>Hormez R. Guard, M.D.</b>  |                         |  | ADDRESS<br><b>111 Penn Street, Balto MD 21201</b>   |   |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |                         | 23b. DATE<br><b>3/2/82</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Woodlawn Cemetery</b>  |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Woodlawn Baltimore MD</b>                     |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Loring Byers Funeral Directors, Inc. 21133</b>   |                         |  |   | 25a. DATE REC'D. BY REGISTRAR<br><b>MAR 1 1982</b>  |   | 25b. REGISTRAR'S SIGNATURE<br><b>James J. Wither</b>   |   |  |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS ANTICIPATED, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF, MEDICAL EXAMINER, ALONG WITH FORM PM 3. RETAIN PAGE 4 IN YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.



RECEIVED  
JAN 10 1900  
U.S. DEPT. OF AGRICULTURE  
WASHINGTON, D.C.

Wm. H. H. H.

1- FOR  
STATE  
REGISTRAR

REG. NO.

|   |  |   |   |  |  |
|---|--|---|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>ELEANOR K. RADER   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>2 8 82                                 |  | 2b. HOUR<br>1:35 A.M.  |
| 3. SEX<br>FEMALE  | 4. RACE<br>CAUC  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>04 30 13  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>68 YRS.                                    |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>UNK MD   | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.                    |  |  |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>SINAI HOSPITAL OF BALTIMORE, INC. |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>HOUSEWIFE | 12b. KIND OF BUSINESS OR INDUSTRY<br>UNK SELF  |  |
| 13a. STATE<br>MARYLAND  |  |   | 13b. COUNTY<br>BALTO  | 13c. CITY OR TOWN<br>PIKESVILLE  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                            |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>CLAUDE T. KIMMEY  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>ANNA YINGLING                |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>UNK NO  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>219-60-2825  | 17. INFORMANT<br>ADDRESS<br>CHARLES F. RADER JR. (SAME)                       |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) CARDIOGENIC SHOCK<br>4100 DUE TO, OR AS A CONSEQUENCE OF<br>(b) ACUTE ANTEROSEPTAL MI<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(c) DUE TO, OR AS A CONSEQUENCE OF |  |   |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)  |  |   |   |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)       |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                   |  |   |   |  |  |
| 22b. SIGNATURE<br>Dspatyl<br>D.S. PATEL   |  | DEGREE<br>MD<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>  |   | 22c. DATE SIGNED<br>2.8.82.  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>D.S. PATEL   |  | 22e. ADDRESS<br>SINAI HOSPITAL  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>ENTOMBMENT  | 23b. DATE<br>2/10/82   | 23c. NAME OF CEMETERY OR CREMATORY<br>DRUIDRIDGE CEMETERY   |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>PIKESVILLE BALTO MD.                   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>NEWELL F. H. PIKESVILLE MD.   |  | 25a. DATE REC'D. BY REGISTRAR<br>FEB 9 1982   |   |  |  |
| 25b. REGISTRAR'S SIGNATURE<br>James Santhorn  |  |   |   |  |  |

MEDICAL CERTIFICATION

29

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Force may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified at 351-1212.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 4 1 2 4

REG. NO.

|  |  |   |  |   |                           |   |  |  |  |  |  |
|--|--|---|--|---|---------------------------|---|--|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>HARRY — RAIVEL SR.</b>  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>02/16/82</b> |   | 2b. HOUR<br>M<br><b>M</b> |   |  |  |  |  |  |
| 3. SEX<br><b>Male</b>  |  | 4. RACE<br><b>Caucasian</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>6 2 1918</b>   |                           | 6. AGE (IN YEARS LAST BIRTHDAY)<br>YRS<br><b>63</b>   |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br><b>0 0</b>   |  | IF UNDER 24 HRS<br>HOURS MIN.<br><b>0 0</b>  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                           | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.                               |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Baltimore City Hospital</b> |  |   |                           | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Printer</b>              |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Rudman and Levine</b>  |  |  |  |
| 13a. STATE<br><b>Maryland</b>  |  | 13b. COUNTY<br><b>Baltimore</b>   |  | 13c. CITY OR TOWN<br><b>Dundalk</b>   |                           | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>2007 Ormond Road</b>   |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>George F. Raivel</b>  |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Frances Zellers</b>   |                           |   |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>Yes WW II</b>       |  |  |  |
| 16b. SOCIAL SECURITY NO.<br><b>216-09-1277</b>   |  |   |  | 17. INFORMANT<br><b>Ann Marie Raivel</b>  |                           |   |  | ADDRESS<br><b>2007 Ormond Road Balto., MD. 21222</b>   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARDIAC ARREST</b><br><b>4100</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>MYOCARDIAL INFARCTION</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |  |   |  |   |                           |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) _____  |  |   |  |   |                           |   |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |                           | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |                           |   |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21i. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |                           |   |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>2/6/82</b> , 19 <b>82</b> , to <b>2/6/82</b> , 19 <b>82</b> , that (I) (we) last saw the deceased alive on <b>2/6/82</b> , 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.                     |  |   |  |   |                           |   |  |  |  |  |  |
| 22b. SIGNATURE<br><b>Gordon Raphael</b>  |  |   |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>        |                           |   |  | 22c. DATE SIGNED<br><b>2/6/82</b>  |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>GORDON RAPHAEL</b>   |  |   |  | 22e. ADDRESS<br><b>Baltimore City Hospital</b>  |                           |   |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>2/20/1982</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Oak Lawn</b>   |                           | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Maryland</b>                         |  |  |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Duda-Ruck, Inc. 7922 Wise Avenue Dundalk, MD. 21222</b>   |  |   |  |   |                           | 25a. DATE REC'D. BY REGISTRAR<br><b>FEB 22 1982</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Ann Mathews</b>   |  |  |  |





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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed in 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

1. FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 4 1 2 5

REG. NO.

|  |  |  |  |   |  |   |  |
|--|--|--|--|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>HAROLD (Harry) RAND</b>   |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>2 9 82</b> |   | 2b. HOUR<br><b>11:50 PM</b>  |   |  |
| 3. SEX<br><b>MALE</b>  |  | 4. RACE<br><b>WHITE</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>3- 28 23</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>58</b> YRS.   |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br><b>NEW JERSEY</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY, MD</b>                               |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>VETERANS ADMINISTRATION MEDICAL CENTER</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF LAST YEAR)<br><b>Director of Volunteers</b>  |  |
| 13a. STATE<br><b>MARYLAND</b>  |  | 13b. COUNTY<br><b>Baltimore</b>  |  | 13c. CITY OR TOWN<br><b>Ft. Howard</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>CHARLES RAND</b>  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>MINNIE</b>   |  | 13e. STREET ADDRESS<br><b>Ft. Howard VAMC</b>   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>YES WWII</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>138165259</b>   |  | 17. INFORMANT<br><b>David S. Rand - Morristown, N. J. 07960</b>   |  |   |  |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Acute myocardial infarction</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Coronary Artery Disease</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.   |  |  |  |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)<br><b>Duodenal ulcer</b>  |  |  |  |   |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>FEBRUARY 8</b> , 19 <b>82</b> , to <b>FEBRUARY 9</b> , 19 <b>82</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>FEBRUARY 9</b> , 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) (did) (did not) view the body after death. |  |  |  |   |  |   |  |
| 22b. SIGNATURE<br><b>Jan Laws Houghton MD</b>  |  |  |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>        |  | 22c. DATE SIGNED<br><b>2/10/82</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Jan Laws Houghton</b>  |  |  |  | 22e. ADDRESS<br><b>3900 Loch Raven Blvd. Balto. Md. 21218</b>   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Cremation</b>   |  | 23b. DATE<br><b>2/11/82</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Westview Mem. Park</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore, Maryland</b>                        |  |
| 24. FUNERAL DIRECTOR <b>Duda-Ruck, Inc.</b><br>NAME ADDRESS<br><b>7922 Wise Avenue, Dundalk, MD 21222</b>  |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>FEB 16 1982</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>James J. Math</b>  |  |



October 1940

From the [illegible]

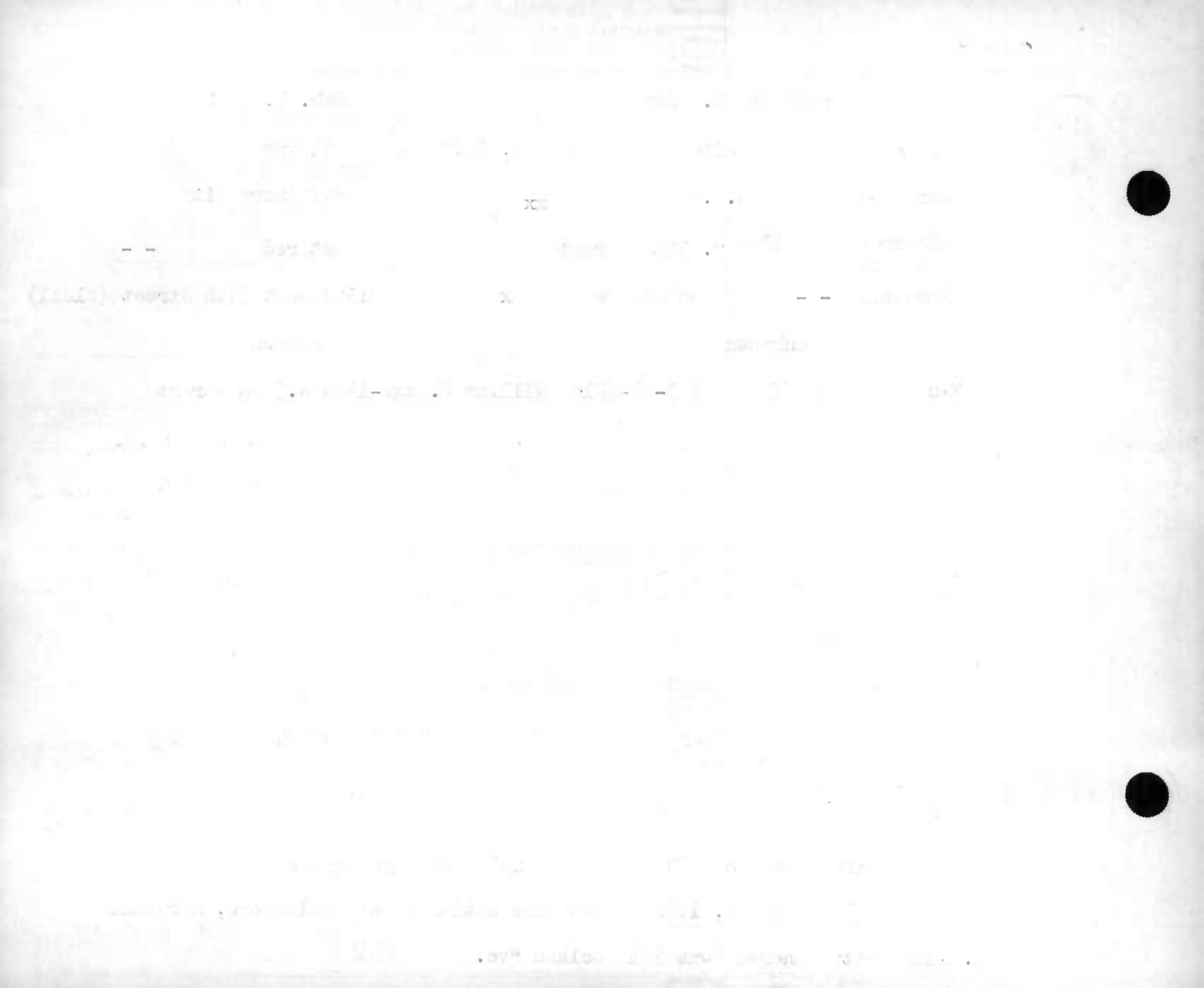
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers, Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  | 8 2 0 4 1 2 6   |  |  |  |
|---|--|--|--|---|--|--|--|
| FOR<br>STATE<br>REGISTRAR   |  |  |  | REG. NO.  |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Franklin W. Ray  |  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>Feb. 4, 1982   |  | 2b. HOUR<br>M  |  |
| 3. SEX<br>Male  |  | 4. RACE<br>White   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>Aug 25, 1910  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>71 yrs YRS.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD  |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>1340 W. 37th Street |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Retired   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>--  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE 13b. COUNTY 13c. CITY OR TOWN<br>Maryland -- Baltimore   |  |  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 13e. STREET ADDRESS<br>1340 West 37th Street (21211)   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>unknown   |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>unknown  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>Yes WW II   |  |  |  | 16b. SOCIAL SECURITY NO.<br>213-03-2216   |  | 17. INFORMANT<br>ADDRESS<br>William F. Ray-1340 W. 37th Street   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>CVA</u><br>4292<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>a.s.c. V.D.</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>several years</u><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>immediate</u> |  |  |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><u>arthritis</u> <u>several years</u>  |  |  |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>3-9</u> , 19 <u>77</u> , to <u>2-4</u> , 19 <u>82</u> , that (I) (we) lost saw the deceased alive on <u>2-3</u> , 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.   |  |  |  |   |  |  |  |
| 22b. SIGNATURE<br><u>E. Ellsworth Cook</u> MD. DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>   |  |  |  | 22c. DATE SIGNED<br><u>2-5-82</u>   |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Ellsworth Cook, MD   |  |  |  | 22e. ADDRESS<br>2431 Maryland Avenue  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial  |  | 23b. DATE<br>Feb 8, 1982   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Baltimore National Cem  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore, Maryland  |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br>A. Alan Seitz Funeral Home 3818 Roland Ave.   |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br>FEB 8 1982   |  | 25b. REGISTRAR'S SIGNATURE<br><u>James J. [Signature]</u>  |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |   |   |   |  |  |   |                                   |  |                 | 8 2 0 4 1 2 7                                   |      |
|---|---|---|---|--|--|---|-----------------------------------|--|-----------------|---|------|
| 1. FOR<br>STATE<br>REGISTRAR  |   | REG. NO.  |   |  |  |   |                                   |  |                 |   |      |
| I. DECEASED NAME<br>(TYPE OR PRINT)   |   | FIRST   | MIDDLE  | LAST   | 2a. DATE OF DEATH  |   | MONTH                             | DAY  | YEAR            | 2b. HOUR  | PM   |
| Paul Edward Rebok   |   |   |   |  | 2  |   | 18                                | 82   | 12:30           | AM  |      |
| 3. SEX  | 4. RACE   | 5. DATE OF BIRTH  |   |  | 6. AGE (IN YEARS LAST BIRTHDAY)                                  |   | IF UNDER 1 YEAR                   |  | IF UNDER 24 HRS |   |      |
| Male  | White   | 9 27 10   |   |  | 71   |   | MONTHS                            |  | DAYS            | HOURS   | MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   | 7b. CITIZEN OF WHAT COUNTRY?  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                             |   |                                   |  |                 |   |      |
| Pennsylvania  | U.S.A.  |   |   |  | Baltimore City MD.   |   |                                   |  |                 |   |      |
| 10. CITY OR TOWN OF DEATH   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |   |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE) |   | 12b. KIND OF BUSINESS OR INDUSTRY |  |                 |   |      |
| Baltimore   | St. Agnes Hospital  |   |   |  | Machinist-Crown Cork &   |   | Seal                              |  |                 |   |      |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |   |   |   |  |  |   |                                   |  |                 |   |      |
| 13a. STATE  | 13b. COUNTY   | 13c. CITY OR TOWN   | 13d. INSIDE CITY LIMITS?  | 13e. STREET ADDRESS  |  |   |                                   |  |                 |   |      |
| Md.   | A.A. Co.  | Riviera Bch   | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 247 Carvel Rd.   |  |   |                                   |  |                 |   |      |
| 14. FATHER'S NAME   |   |   |   | 15. MOTHER'S MAIDEN NAME   |  |   |                                   |  |                 |   |      |
| FIRST MIDDLE LAST   |   |   |   | FIRST MIDDLE LAST  |  |   |                                   |  |                 |   |      |
| Joseph Rebok  |   |   |   | Mary Ellen Foster  |  |   |                                   |  |                 |   |      |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)  |   |   |   | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT ADDRESS   |                                   |  |                 |   |      |
| NO  |   |   |   | 173 03 0729  |  | Virginia Rebok same as 13 e   |                                   |  |                 |   |      |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:  |   |   |   |  |  |   |                                   |  |                 | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |      |
| IMMEDIATE CAUSE (a) <u>Cardiopulmonary arrest.</u>  |   |   |   |  |  |   |                                   |  |                 | 1 day   |      |
| DUE TO, OR AS A CONSEQUENCE OF (b) <u>cardiac arrhythmia</u>  |   |   |   |  |  |   |                                   |  |                 | 16 days   |      |
| DUE TO, OR AS A CONSEQUENCE OF (c) <u>Bladder tumor - metastasis</u>  |   |   |   |  |  |   |                                   |  |                 | 17 years  |      |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:  |   |   |   |  |  |   |                                   |  |                 |   |      |
| 19a. DATE OF OPERATION  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   |  |  | 20a. AUTOPSY?   |                                   | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?  |                 |   |      |
|   |   | NO  |   |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                   | YES <input type="checkbox"/> NO <input type="checkbox"/>   |                 |   |      |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |   |                                   |  |                 |   |      |
|   |   | P.M. 19   |   |  |  |   |                                   |  |                 |   |      |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |   |                                   |  |                 |   |      |
|   |   |   |   |  |  |   |                                   |  |                 |   |      |
| 22a. I certify that (a) the hospital attended the deceased from <u>1/31/82</u> , 19 <u>82</u> , to <u>2/18</u> , 19 <u>82</u> , that (I) (we) lost<br>saw the deceased alive on <u>2/18/82</u> , 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |   |   |   |  |  |   |                                   |  |                 |   |      |
| 22b. SIGNATURE<br><u>[Signature]</u>  |   |   |   |  |  |   |                                   | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |                 | 22c. DATE SIGNED<br><u>2/18/82</u>              |      |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>SAMIM CHALABI  |   |   |   |  |  | 22e. ADDRESS  |                                   |  |                 |   |      |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)  |   | 23b. DATE   |   | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE                          |                                   |  |                 |   |      |
| Cremation   |   | 2/19/82   |   | Westview Mem Park  |  | Baltimore, Maryland   |                                   |  |                 |   |      |
| 24. FUNERAL DIRECTOR<br>George J. Gonce Balto Md. 21225   |   |   |   |  |  | 25a. DATE REC'D. BY REGISTRAR                                       |                                   | 25b. REGISTRAR'S SIGNATURE<br><u>[Signature]</u>   |                 |   |      |
| 4001 Ritchie Hgwy   |   |   |   |  |  | FEB 19 1982   |                                   |  |                 |   |      |

MEDICAL CERTIFICATION

29





TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM FM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS, AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |  |                         |  |  |   |  |  |   |   | REG. NO. 7204128  |  |  |  |
|--|--|-------------------------|--|--|---|--|--|---|---|---|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br><b>JOHNSON REDD</b>  |  |                         |  |  |   |  |  |   |   | 2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> 2-11-82 <input type="checkbox"/> MONTH DAY YEAR |  | 2b. HOUR <input type="checkbox"/> M <input type="checkbox"/> M |  |
| 3. SEX<br><b>male</b>  |  | 4. RACE<br><b>black</b> |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>5 30 00</b>              |   | 6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS HOURS MIN.<br><b>81 YRS.</b>   |  | 7c. DATE PRONOUNCED DEAD<br><b>2-12-82</b>                    |   | 2d. HOUR <input type="checkbox"/> M <input type="checkbox"/> M  |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Va</b>   |  |                         | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD. |   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |  |                         | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>425 E. 23rd Street</b> |  |   |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) |   | 12b. KIND OF BUSINESS OR INDUSTRY   |  |  |  |
| 13a. STATE<br><b>Md</b>  |  |                         | 13b. COUNTY  |  | 13c. CITY OR TOWN<br><b>Baltimore</b>                           |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   | 13e. STREET ADDRESS<br><b>425 E. 23rd Street</b>                  |   |  |  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>Unknown</b>  |  |                         |  |  |   | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Unknown</b>   |  |   |   |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)<br><b>No</b>  |  |                         | 16b. SOCIAL SECURITY NO.<br><b>717-07-6303</b>   |  |   | 17. INFORMANT ADDRESS<br><b>Mary Evans 1111 Courtland St Peekskill N.Y.</b>  |  |   |   |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Arteriosclerotic cardiovascular disease</b><br><b>4292</b><br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost:<br>(b) _____<br>(c) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>DUE TO, OR AS A CONSEQUENCE OF   |  |                         |  |  |   |  |  |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).  |  |                         |  |  |   |  |  |   |   |   |  |  |  |
| 19a. DATE OF OPERATION   |  |                         |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?              |   |  |  |   |   | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                      |  |  |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  |                         |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b> |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)  |  |   |   |   |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK  |  |                         |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)    |   | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |   |   |   |  |  |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . |  |                         |  |  |   |  |  |   |   |   |  |  |  |
| ACTUAL SIGNATURE <b>Margareta A. Korell</b>  |  |                         |  | TITLE (SPECIFY) <b>Assistant</b>                               |   |  |  | DATE SIGNED <b>2-13-82</b>                                    |   |   |  |  |  |
| EXAMINER'S NAME (TYPE OR PRINT) <b>Margarita A. Korell, M.D.</b>   |  |                         |  | ADDRESS <b>111 Penn Street</b>                                 |   |  |  |   |   |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |  |                         | 23b. DATE<br><b>2/19/82</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>King Memorial Park</b> |  |  | 23d. LOCATION CITY OR TOWN<br><b>Balto</b>                    |   | COUNTY <b>Co</b> STATE <b>Md</b>  |  |  |  |
| 24. FUNERAL DIRECTOR NAME<br><b>William C. March F/H 1101 E. North Avenue</b>  |  |                         |  |  |   | 25a. DATE REC'D. BY REGISTRAR<br><b>FEB 17 1982</b>  |  | 25b. REGISTRAR'S SIGNATURE <b>James J. Martin</b>             |   |   |  |  |  |



RECEIVED  
BOND



FEB 11 1964

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of this.

DHMH-16 30M 2/80  
(VRA 15, 4)

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |   |   |   |   |   |  |  |
|---|--|--|---|---|---|---|---|--|--|
| 1. FOR<br>STATE<br>REGISTRAR  |  | REG. NO. 8 2 0 4 1 2 9   |   |   |   |   |   |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br>Mary Loretta Reddington  |  |  |   |   | 2a. DATE OF DEATH MONTH DAY YEAR<br>2 28 82   |   | 2b. HOUR<br>M   |  |  |
| 3. SEX<br>Female  |  | 4. RACE<br>White   |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>Dec 26, 1896  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>85 yrs   |   | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A  |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Balto. City MD.   |   |  |  |
| 10. CITY OR TOWN OF DEATH<br>Balto. City  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Union Memorial Hospital |   |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Housewife                   |   | 12b. KIND OF BUSINESS OR INDUSTRY<br>---   |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE Maryland 13b. COUNTY -- 13c. CITY OR TOWN Baltimore   |  |  |   |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   | 13e. STREET ADDRESS<br>4121 Falls Road (21211)                    |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Garland   |  |  |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>unk  |   |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>no --   |  |  | 16b. SOCIAL SECURITY NO.<br>214-74-4821 |   | 17. INFORMANT ADDRESS<br>Elmira, N.Y.<br>Laurence J. Reddington-281 Mulberry ave.               |   |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) ④ Cerebrovascular accident<br>4360<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. |  |  |   |   |   |   |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br>NONE KNOWN   |  |  |   |   |   |   |   |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   |   |   | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |   |   |   |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |   |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 2/26, 19 82, to 2/28, 19 82, that (I) (we) lost saw the deceased alive on 2/28, 19 82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |  |   |   |   |   |   |  |  |
| 22b. SIGNATURE<br>L J Matthews MD   |  |  |   |   | DEGREE<br>MD  |   |   | 22c. DATE SIGNED<br>2/28/82  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Laurie J Matthews MD   |  |  |   |   | 22e. ADDRESS<br>201 E. university PKway   |   |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial  |  | 23b. DATE<br>3/4/82  |   | 23c. NAME OF CEMETERY OR CREMATORY<br>St. Marys Cemetery (Gorans)   |   |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore, Maryland |  |  |
| 24. FUNERAL DIRECTOR<br>A. Alan Seitz Funeral Home  |  |  |   |   | 25a. DATE REC'D. BY REGISTRAR<br>MAR 2 1982   |   | 25b. REGISTRAR'S SIGNATURE<br>Thane Jan Nathan                    |  |  |

MEDICAL CERTIFICATION

19

1



1307 BP

18

| NAME            | DATE         | TIME  | LOCATION            | REMARKS  |
|-----------------|--------------|-------|---------------------|----------|
| Mr. J. A. Smith | Dec 26, 1905 | 10:30 | St. Mary's Cemetery | Interred |
| Mr. J. A. Smith | Dec 26, 1905 | 11:00 | St. Mary's Cemetery | Interred |
| Mr. J. A. Smith | Dec 26, 1905 | 11:30 | St. Mary's Cemetery | Interred |
| Mr. J. A. Smith | Dec 26, 1905 | 12:00 | St. Mary's Cemetery | Interred |
| Mr. J. A. Smith | Dec 26, 1905 | 12:30 | St. Mary's Cemetery | Interred |
| Mr. J. A. Smith | Dec 26, 1905 | 13:00 | St. Mary's Cemetery | Interred |
| Mr. J. A. Smith | Dec 26, 1905 | 13:30 | St. Mary's Cemetery | Interred |
| Mr. J. A. Smith | Dec 26, 1905 | 14:00 | St. Mary's Cemetery | Interred |
| Mr. J. A. Smith | Dec 26, 1905 | 14:30 | St. Mary's Cemetery | Interred |
| Mr. J. A. Smith | Dec 26, 1905 | 15:00 | St. Mary's Cemetery | Interred |
| Mr. J. A. Smith | Dec 26, 1905 | 15:30 | St. Mary's Cemetery | Interred |
| Mr. J. A. Smith | Dec 26, 1905 | 16:00 | St. Mary's Cemetery | Interred |
| Mr. J. A. Smith | Dec 26, 1905 | 16:30 | St. Mary's Cemetery | Interred |
| Mr. J. A. Smith | Dec 26, 1905 | 17:00 | St. Mary's Cemetery | Interred |
| Mr. J. A. Smith | Dec 26, 1905 | 17:30 | St. Mary's Cemetery | Interred |
| Mr. J. A. Smith | Dec 26, 1905 | 18:00 | St. Mary's Cemetery | Interred |
| Mr. J. A. Smith | Dec 26, 1905 | 18:30 | St. Mary's Cemetery | Interred |
| Mr. J. A. Smith | Dec 26, 1905 | 19:00 | St. Mary's Cemetery | Interred |
| Mr. J. A. Smith | Dec 26, 1905 | 19:30 | St. Mary's Cemetery | Interred |
| Mr. J. A. Smith | Dec 26, 1905 | 20:00 | St. Mary's Cemetery | Interred |
| Mr. J. A. Smith | Dec 26, 1905 | 20:30 | St. Mary's Cemetery | Interred |
| Mr. J. A. Smith | Dec 26, 1905 | 21:00 | St. Mary's Cemetery | Interred |
| Mr. J. A. Smith | Dec 26, 1905 | 21:30 | St. Mary's Cemetery | Interred |
| Mr. J. A. Smith | Dec 26, 1905 | 22:00 | St. Mary's Cemetery | Interred |
| Mr. J. A. Smith | Dec 26, 1905 | 22:30 | St. Mary's Cemetery | Interred |
| Mr. J. A. Smith | Dec 26, 1905 | 23:00 | St. Mary's Cemetery | Interred |
| Mr. J. A. Smith | Dec 26, 1905 | 23:30 | St. Mary's Cemetery | Interred |
| Mr. J. A. Smith | Dec 26, 1905 | 24:00 | St. Mary's Cemetery | Interred |

19

St. Mary's Cemetery (General) Baltimore, Maryland  
A. Alan Smith General Home 2018 Roland Ave. Baltimore, Maryland

HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be called at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |   |   |   |  |  |                            |  |
|--|--|--|--|---|---|---|--|--|----------------------------|--|
| 1. FOR STATE REGISTRAR   |  |  |  |   |   |   |  |  |                            |  |
| 1 DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>Willis F. REDFORD SR.  |  |  |  |   | 2a. DATE OF DEATH MONTH DAY YEAR<br>FEB 1 82                |   |  |  |                            |  |
| 3. SEX<br>Male   |  | 4. RACE<br>White   |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>5 29 1896  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>85 YRS.  |  | 2b. HOUR<br>4 A M  |                            |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore MD.   |  |  |                            |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>St. Agnes Hospital |  |   |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Auto Mechanic                  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |                            |  |
| 13a. STATE<br>Maryland   |  | 13b. COUNTY<br>Baltimore   |  | 13c. CITY OR TOWN   |   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS<br>623 48th. Street  |                            |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>Thomas Redford  |  |  |  |   | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Clara Hopkins |   |  |  |                            |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) [IF YES, GIVE WAR OR DATES]<br>No  |  | 16b. SOCIAL SECURITY NO.<br>215-03-9010  |  | 17. INFORMANT ADDRESS<br>Willis F. Redford, Jr. - Balto., MD. 21224   |   |   |  |  |                            |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Acute Left Ventricular Dysfunction</u><br>4149<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:<br>(b) <u>Coronary Heart Disease</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>Due to, or as a consequence of</u><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |  |  |   |   |   |  |  |                            |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><u>Metastatic Prostate Carcinoma, Pneumonia</u>   |  |  |  |   |   |   |  |  |                            |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                            |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |   |   |  |  |                            |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |   |  |  |                            |  |
| 22. I certify that (I) (this hospital) attended the deceased from <u>Jan. 18</u> 19 <u>82</u> , to <u>Jan 31</u> 19 <u>82</u> , that (I) (we) last saw the deceased alive on <u>Jan 31</u> 19 <u>82</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |  |  |   |   |   |  |  |                            |  |
| 22a. SIGNATURE<br><u>Oscar Hernandez</u>   |  |  |  |   | DEGREE<br>M.D.  |   | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br>2-1-82 |  |
| 22b. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Oscar Hernandez   |  |  |  |   | 22e. ADDRESS  |   |  |  |                            |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial  |  | 23b. DATE<br>2/3/1982  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Gardens Of Faith  |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore Maryland                                |  |  |                            |  |
| 24. FUNERAL DIRECTOR<br>NAME Duda-Ruck, Inc.<br>ADDRESS 7922 Wise Avenue Dundalk, MD. 21222  |  |  |  |   | 25a. DATE REC'D. BY REGISTRAR<br>FEB 3 1982                 |   | 25b. REGISTRAR'S SIGNATURE<br><u>Rose Jan. Norton</u>  |  |                            |  |

1-1-58

RECEIVED

NOV 11 1958

1-1-58

NOV 11 1958





STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 4 1 3 1

FOR  
1. STATE  
REGISTRAR

REG. NO.

|   |   |   |  |   |   |
|---|---|---|--|---|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>James John Redmond   |   |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>2 15 82   |   | 2b. HOUR<br>M   |
| 3. SEX<br>Male  | 4. RACE<br>White  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>11 7 1924   |  | 6. AGE (IN YEARS) (LAST BIRTHDAY)<br>57 YRS.              |   |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br>Maryland  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD |   |
| 10. CITY OR TOWN OF DEATH<br>Baltimore  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Baltimore City Hospitals |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Inspector  |   | 12b. KIND OF BUSINESS OR INDUSTRY<br>Gen. Motors  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13b. STATE<br>Maryland  |   |   | 13c. COUNTY<br>Baltimore   | 13d. CITY OR TOWN<br>Dundalk                              | 13e. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Charles J. Redmond  |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Bessie Beitler  |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>No  |   | 16b. SOCIAL SECURITY NO.<br>218-12-3871   |  | 17. INFORMANT<br>John J. Redmond                          |   |
| 18a. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>4960 IMMEDIATE CAUSE (a) Respiratory insufficiency<br>DUE TO, OR AS A CONSEQUENCE OF Chronic obstructive pulmonary disease<br>(b)<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>2 hours<br>8 yrs |   |   | PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a)<br>(b)<br>(c)<br>(d)<br>(e)<br>(f)<br>(g)<br>(h)<br>(i)<br>(j)<br>(k)<br>(l)<br>(m)<br>(n)<br>(o)<br>(p)<br>(q)<br>(r)<br>(s)<br>(t)<br>(u)<br>(v)<br>(w)<br>(x)<br>(y)<br>(z)<br>(aa)<br>(ab)<br>(ac)<br>(ad)<br>(ae)<br>(af)<br>(ag)<br>(ah)<br>(ai)<br>(aj)<br>(ak)<br>(al)<br>(am)<br>(an)<br>(ao)<br>(ap)<br>(aq)<br>(ar)<br>(as)<br>(at)<br>(au)<br>(av)<br>(aw)<br>(ax)<br>(ay)<br>(az)<br>(ba)<br>(bb)<br>(bc)<br>(bd)<br>(be)<br>(bf)<br>(bg)<br>(bh)<br>(bi)<br>(bj)<br>(bk)<br>(bl)<br>(bm)<br>(bn)<br>(bo)<br>(bp)<br>(bq)<br>(br)<br>(bs)<br>(bt)<br>(bu)<br>(bv)<br>(bw)<br>(bx)<br>(by)<br>(bz)<br>(ca)<br>(cb)<br>(cc)<br>(cd)<br>(ce)<br>(cf)<br>(cg)<br>(ch)<br>(ci)<br>(cj)<br>(ck)<br>(cl)<br>(cm)<br>(cn)<br>(co)<br>(cp)<br>(cq)<br>(cr)<br>(cs)<br>(ct)<br>(cu)<br>(cv)<br>(cw)<br>(cx)<br>(cy)<br>(cz)<br>(da)<br>(db)<br>(dc)<br>(dd)<br>(de)<br>(df)<br>(dg)<br>(dh)<br>(di)<br>(dj)<br>(dk)<br>(dl)<br>(dm)<br>(dn)<br>(do)<br>(dp)<br>(dq)<br>(dr)<br>(ds)<br>(dt)<br>(du)<br>(dv)<br>(dw)<br>(dx)<br>(dy)<br>(dz)<br>(ea)<br>(eb)<br>(ec)<br>(ed)<br>(ee)<br>(ef)<br>(eg)<br>(eh)<br>(ei)<br>(ej)<br>(ek)<br>(el)<br>(em)<br>(en)<br>(eo)<br>(ep)<br>(eq)<br>(er)<br>(es)<br>(et)<br>(eu)<br>(ev)<br>(ew)<br>(ex)<br>(ey)<br>(ez)<br>(fa)<br>(fb)<br>(fc)<br>(fd)<br>(fe)<br>(ff)<br>(fg)<br>(fh)<br>(fi)<br>(fj)<br>(fk)<br>(fl)<br>(fm)<br>(fn)<br>(fo)<br>(fp)<br>(fq)<br>(fr)<br>(fs)<br>(ft)<br>(fu)<br>(fv)<br>(fw)<br>(fx)<br>(fy)<br>(fz)<br>(ga)<br>(gb)<br>(gc)<br>(gd)<br>(ge)<br>(gf)<br>(gg)<br>(gh)<br>(gi)<br>(gj)<br>(gk)<br>(gl)<br>(gm)<br>(gn)<br>(go)<br>(gp)<br>(gq)<br>(gr)<br>(gs)<br>(gt)<br>(gu)<br>(gv)<br>(gw)<br>(gx)<br>(gy)<br>(gz)<br>(ha)<br>(hb)<br>(hc)<br>(hd)<br>(he)<br>(hf)<br>(hg)<br>(hh)<br>(hi)<br>(hj)<br>(hk)<br>(hl)<br>(hm)<br>(hn)<br>(ho)<br>(hp)<br>(hq)<br>(hr)<br>(hs)<br>(ht)<br>(hu)<br>(hv)<br>(hw)<br>(hx)<br>(hy)<br>(hz)<br>(ia)<br>(ib)<br>(ic)<br>(id)<br>(ie)<br>(if)<br>(ig)<br>(ih)<br>(ii)<br>(ij)<br>(ik)<br>(il)<br>(im)<br>(in)<br>(io)<br>(ip)<br>(iq)<br>(ir)<br>(is)<br>(it)<br>(iu)<br>(iv)<br>(iw)<br>(ix)<br>(iy)<br>(iz)<br>(ja)<br>(jb)<br>(jc)<br>(jd)<br>(je)<br>(jf)<br>(jg)<br>(jh)<br>(ji)<br>(jj)<br>(jk)<br>(jl)<br>(jm)<br>(jn)<br>(jo)<br>(jp)<br>(jq)<br>(jr)<br>(js)<br>(jt)<br>(ju)<br>(jv)<br>(jw)<br>(jx)<br>(jy)<br>(jz)<br>(ka)<br>(kb)<br>(kc)<br>(kd)<br>(ke)<br>(kf)<br>(kg)<br>(kh)<br>(ki)<br>(kj)<br>(kk)<br>(kl)<br>(km)<br>(kn)<br>(ko)<br>(kp)<br>(kq)<br>(kr)<br>(ks)<br>(kt)<br>(ku)<br>(kv)<br>(kw)<br>(kx)<br>(ky)<br>(kz)<br>(la)<br>(lb)<br>(lc)<br>(ld)<br>(le)<br>(lf)<br>(lg)<br>(lh)<br>(li)<br>(lj)<br>(lk)<br>(ll)<br>(lm)<br>(ln)<br>(lo)<br>(lp)<br>(lq)<br>(lr)<br>(ls)<br>(lt)<br>(lu)<br>(lv)<br>(lw)<br>(lx)<br>(ly)<br>(lz)<br>(ma)<br>(mb)<br>(mc)<br>(md)<br>(me)<br>(mf)<br>(mg)<br>(mh)<br>(mi)<br>(mj)<br>(mk)<br>(ml)<br>(mm)<br>(mn)<br>(mo)<br>(mp)<br>(mq)<br>(mr)<br>(ms)<br>(mt)<br>(mu)<br>(mv)<br>(mw)<br>(mx)<br>(my)<br>(mz)<br>(na)<br>(nb)<br>(nc)<br>(nd)<br>(ne)<br>(nf)<br>(ng)<br>(nh)<br>(ni)<br>(nj)<br>(nk)<br>(nl)<br>(nm)<br>(nn)<br>(no)<br>(np)<br>(nq)<br>(nr)<br>(ns)<br>(nt)<br>(nu)<br>(nv)<br>(nw)<br>(nx)<br>(ny)<br>(nz)<br>(oa)<br>(ob)<br>(oc)<br>(od)<br>(oe)<br>(of)<br>(og)<br>(oh)<br>(oi)<br>(oj)<br>(ok)<br>(ol)<br>(om)<br>(on)<br>(oo)<br>(op)<br>(oq)<br>(or)<br>(os)<br>(ot)<br>(ou)<br>(ov)<br>(ow)<br>(ox)<br>(oy)<br>(oz)<br>(pa)<br>(pb)<br>(pc)<br>(pd)<br>(pe)<br>(pf)<br>(pg)<br>(ph)<br>(pi)<br>(pj)<br>(pk)<br>(pl)<br>(pm)<br>(pn)<br>(po)<br>(pp)<br>(pq)<br>(pr)<br>(ps)<br>(pt)<br>(pu)<br>(pv)<br>(pw)<br>(px)<br>(py)<br>(pz)<br>(qa)<br>(qb)<br>(qc)<br>(qd)<br>(qe)<br>(qf)<br>(qg)<br>(qh)<br>(qi)<br>(qj)<br>(qk)<br>(ql)<br>(qm)<br>(qn)<br>(qo)<br>(qp)<br>(qq)<br>(qr)<br>(qs)<br>(qt)<br>(qu)<br>(qv)<br>(qw)<br>(qx)<br>(qy)<br>(qz)<br>(ra)<br>(rb)<br>(rc)<br>(rd)<br>(re)<br>(rf)<br>(rg)<br>(rh)<br>(ri)<br>(rj)<br>(rk)<br>(rl)<br>(rm)<br>(rn)<br>(ro)<br>(rp)<br>(rq)<br>(rr)<br>(rs)<br>(rt)<br>(ru)<br>(rv)<br>(rw)<br>(rx)<br>(ry)<br>(rz)<br>(sa)<br>(sb)<br>(sc)<br>(sd)<br>(se)<br>(sf)<br>(sg)<br>(sh)<br>(si)<br>(sj)<br>(sk)<br>(sl)<br>(sm)<br>(sn)<br>(so)<br>(sp)<br>(sq)<br>(sr)<br>(ss)<br>(st)<br>(su)<br>(sv)<br>(sw)<br>(sx)<br>(sy)<br>(sz)<br>(ta)<br>(tb)<br>(tc)<br>(td)<br>(te)<br>(tf)<br>(tg)<br>(th)<br>(ti)<br>(tj)<br>(tk)<br>(tl)<br>(tm)<br>(tn)<br>(to)<br>(tp)<br>(tq)<br>(tr)<br>(ts)<br>(tt)<br>(tu)<br>(tv)<br>(tw)<br>(tx)<br>(ty)<br>(tz)<br>(ua)<br>(ub)<br>(uc)<br>(ud)<br>(ue)<br>(uf)<br>(ug)<br>(uh)<br>(ui)<br>(uj)<br>(uk)<br>(ul)<br>(um)<br>(un)<br>(uo)<br>(up)<br>(uq)<br>(ur)<br>(us)<br>(ut)<br>(uu)<br>(uv)<br>(uw)<br>(ux)<br>(uy)<br>(uz)<br>(va)<br>(vb)<br>(vc)<br>(vd)<br>(ve)<br>(vf)<br>(vg)<br>(vh)<br>(vi)<br>(vj)<br>(vk)<br>(vl)<br>(vm)<br>(vn)<br>(vo)<br>(vp)<br>(vq)<br>(vr)<br>(vs)<br>(vt)<br>(vu)<br>(vv)<br>(vw)<br>(vx)<br>(vy)<br>(vz)<br>(wa)<br>(wb)<br>(wc)<br>(wd)<br>(we)<br>(wf)<br>(wg)<br>(wh)<br>(wi)<br>(wj)<br>(wk)<br>(wl)<br>(wm)<br>(wn)<br>(wo)<br>(wp)<br>(wq)<br>(wr)<br>(ws)<br>(wt)<br>(wu)<br>(wv)<br>(ww)<br>(wx)<br>(wy)<br>(wz)<br>(xa)<br>(xb)<br>(xc)<br>(xd)<br>(xe)<br>(xf)<br>(xg)<br>(xh)<br>(xi)<br>(xj)<br>(xk)<br>(xl)<br>(xm)<br>(xn)<br>(xo)<br>(xp)<br>(xq)<br>(xr)<br>(xs)<br>(xt)<br>(xu)<br>(xv)<br>(xw)<br>(xx)<br>(xy)<br>(xz)<br>(ya)<br>(yb)<br>(yc)<br>(yd)<br>(ye)<br>(yf)<br>(yg)<br>(yh)<br>(yi)<br>(yj)<br>(yk)<br>(yl)<br>(ym)<br>(yn)<br>(yo)<br>(yp)<br>(yq)<br>(yr)<br>(ys)<br>(yt)<br>(yu)<br>(yv)<br>(yw)<br>(yx)<br>(yy)<br>(yz)<br>(za)<br>(zb)<br>(zc)<br>(zd)<br>(ze)<br>(zf)<br>(zg)<br>(zh)<br>(zi)<br>(zj)<br>(zk)<br>(zl)<br>(zm)<br>(zn)<br>(zo)<br>(zp)<br>(zq)<br>(zr)<br>(zs)<br>(zt)<br>(zu)<br>(zv)<br>(zw)<br>(zx)<br>(zy)<br>(zz) |   |   |

MEDICAL CERTIFICATION

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY?

20b. IF YES, WERE FINDINGS USED  
IN CERTIFYING CAUSES OF DEATH?21a. ACCIDENT WAS UNDERLYING ☐  
OR CONTRIBUTING ☐ CAUSE OF DEATH  
(IF EITHER, NOTIFY MEDICAL EXAMINER)21b. TIME OF INJURY  
HOUR A.M. MONTH DAY YEAR  
P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)

21d. INJURY OCCURRED  
WHILE ☐ NOT WHILE ☐  
AT WORK ☐ AT HOME ☐21e. PLACE OF INJURY  
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)21f. LOCATION  
STREET CITY OR TOWN COUNTY STATE22a. I certify that (I) (this hospital) attended the deceased from 6-10 19 82 to 7-15 19 82 that (I) (we) last  
saw the deceased alive on 6-15 19 82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated  
above. (I) (we) (did) (did not) view the body after death.22b. SIGNATURE  
Norris Horwitz, M.D.

DEGREE

ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐

22c. DATE SIGNED

Feb 16 1982

22d. PHYSICIAN'S NAME (TYPE OR PRINT)

Norris Horwitz, M.D.

22e. ADDRESS

601 PARK AVE, BALTO. MD 21201

23a. BURIAL, CREMATION, REMOVAL  
(SPECIFY)

Burial

23b. DATE

2/19/82

23c. NAME OF CEMETERY OR CREMATORY

St. Stanislaus Cem.

23d. LOCATION  
CITY OR TOWN

Baltimore

COUNTY

STATE

Maryland

24. FUNERAL DIRECTOR  
NAME

Duda-Ruck, Inc.

ADDRESS

7922 Wise Avenue, Dundalk, MD 21222

25a. DATE REC'D. BY REGISTRAR

FEB 18 1982

25b. REGISTRAR'S SIGNATURE

Thomas J. Horwitz

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Their please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 1B shows any injury, or other traumatic event, the medical examiner must be notified.



THE UNIVERSITY OF CHICAGO  
LIBRARY

19

19

Chicago University  
Library



Chicago University  
Library

Chicago University  
Library

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified by the funeral director.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |   |  |  |  |   |   | REG. NO.  |  |
|--|--|--|--|---|--|--|--|---|---|---|--|
| 1. FOR<br>STATE<br>REGISTRAR   |  | 1. DECEASED NAME<br>(TYPE OR PRINT)<br>ADOLPH F. REDTMAN   |  |   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>02/18/82  |  |   |   | 2b. HOUR<br>9:15 PM                             |  |
| 3. SEX<br>male   |  | 4. RACE<br>Cauc.   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>11/08/1916  |  | 6. AGE<br>(IN YEARS LAST BIRTHDAY)<br>65 YRS   |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS   |   | 7. IF UNDER 24 HRS.<br>HOURS MIN.               |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN<br>COUNTRY)<br>Maryland  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.   |  |   |   |   |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Good Samaritan Hospital |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Ceiling Install.   |  |   | 12b. KIND OF BUSINESS OR<br>INDUSTRY<br>Baker |   |  |
| 13a. STATE<br>Maryland   |  | 13b. COUNTY  |  | 13c. CITY OR TOWN<br>Baltimore  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 13e. STREET ADDRESS<br>5710 Fair Oaks Ave.  |   |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Frank Otto Redtman   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Louise Barren   |  |   |  |  |  |   |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>214-03-7845   |  | 17. INFORMANT<br>ADDRESS<br>Kathryn S. Redtman, 5710 Fair Oaks Ave.   |  |  |  |   |   |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Respiratory Failure</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>progressive multiple pneumonic consolidations</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>7 4860<br>Conditions, if any, which<br>gave rise to immediate<br>cause (a), stating the<br>underlying cause last. |  |  |  |   |  |  |  |   |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |  |  |   |  |  |  |   |   |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED<br>(ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |  |   |   |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |   |   |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>2/11</u> , 19 <u>82</u> , to <u>2/19</u> , 19 <u>82</u> , that (I) (we) last<br>saw the deceased alive on <u>2/18</u> , 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.   |  |  |  |   |  |  |  |   |   |   |  |
| 22b. SIGNATURE<br>N. Daglama   |  | DEGREE<br>MD   |  |   |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br>Feb. 19, 1982   |   |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>NABIL ZAQLAMA   |  | 22e. ADDRESS<br>The Good Samaritan Hospital  |  |   |  |  |  |   |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Cremation  |  | 23b. DATE<br>Feb. 19, 1982   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Westview  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Catonsville, Balto., Md.   |  |   |   |   |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br>ROBERT C. ALTENBURG FUNERAL HOME, INC.<br>6009 Harford Rd., Balto., Md. 21214  |  |  |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br>FEB 22 1982   |  | 25b. REGISTRAR'S SIGNATURE<br>James J. Mast...  |   |   |  |



*[The page contains extremely faint, illegible text that appears to be bleed-through from the reverse side. The text is organized into several paragraphs and possibly a list or table, but the characters are too light to transcribe accurately.]*

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1b. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITH YOUR FILES AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |                  |  |   |   |   |  |  |   |  | REG. NO. 2 0 4 1 3 3 |  |
|--|------------------|--|---|---|---|--|--|---|--|----------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) Edith Reed   |                  |  |   |   |   | 2a. DATE KNOWN OF DEATH<br>ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 2 13 19 82 |  | 2b. HOUR M 4:45   |  |                      |  |
| 3. SEX<br>female   | 4. RACE<br>white | 5. DATE OF BIRTH<br>MONTH DAY YEAR 10 25 1891  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>90 YRS.                  | IF UNDER 1 YR.<br>MONTHS DAYS HOURS MIN.  | 7c. DATE PRONOUNCED DEAD<br>MONTH DAY YEAR 2 15 19 82                         | 7d. HOUR M 4:45  |  |   |  |                      |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland  |                  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.   |  |   |  |                      |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore   |                  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>3408 Glenmore Avenue |   |   |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Clerk                             |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Dept. Store                                    |  |                      |  |
| 13a. STATE<br>Maryland   |                  | 13b. COUNTY  |   | 13c. CITY OR TOWN<br>Baltimore  |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>    |  | 13e. STREET ADDRESS<br>3408 Glenmore Ave.   |  |                      |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>(UNKNOWN)  |                  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>(UNKNOWN)  |   |  |  |   |  |                      |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br>No  |                  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>212-09-9116   |   | 17. INFORMANT ADDRESS<br>Charles M. Wilson, 1 Trumps Ct.  |   |  |  |   |  |                      |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>4292 IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.<br>(b) DUE TO, OR AS A CONSEQUENCE OF<br>(c)   |                  |  |   |   |   |  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |                      |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).  |                  |  |   |   |   |  |  |   |  |                      |  |
| 19a. DATE OF OPERATION   |                  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?           |   |   |  |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |                      |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |                  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b PART 1 OR PART 2) |  |  |   |  |                      |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |                  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                             |  |  |   |  |                      |  |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |                  |  |   |   |   |  |  |   |  |                      |  |
| ACTUAL SIGNATURE <i>H. Guard</i>   |                  |  |   |   | TITLE (SPECIFY)<br>Assistant  |  |  | DATE SIGNED 2/16/82   |  |                      |  |
| EXAMINER'S NAME (TYPE OR PRINT)<br>Hormez R. Guard, M.D.   |                  |  |   |   | ADDRESS 111 Penn Street, Balto. MD 21201                                      |  |  |   |  |                      |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Cremation   |                  |  | 23b. DATE<br>Feb. 23, 1982                                  |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Westview                                |  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Catonsville, Balto., Md.              |  |                      |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br>ROBERT C. ALTENBURG FUNERAL HOME, INC.<br>6009 Harford Rd., Balto., Md. 21214  |                  |  |   |   | 25a. DATE RECD. BY REGISTRAR<br>FEB 23 1982                                   |  |  | 25b. REGISTRAR'S SIGNATURE  |  |                      |  |

(10/10/10)

(10/10/10)

*Handwritten signature*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  | 8 2 0 4 1 3 4  |  |  |  |
|---|--|---|--|--|--|--|--|
| 1. FOR STATE REGISTRAR  |  |   |  | REG. NO.   |  |  |  |
| I. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br><b>LORRAINE M. REHBERGER</b>   |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR 2b. HOUR<br><b>02 22 82 3<sup>30</sup> P.M.</b>   |  |  |  |
| 3. SEX<br><b>Female</b>   |  | 4. RACE<br><b>White</b>   |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>Feb. 8, 1898</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS HOURS MIN.<br><b>84 YRS.</b>   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Baltimore, Md.</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY Baltimore City, MD.</b>  |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br><b>UNION MEMORIAL HOSPITAL</b> |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Housewife</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>---</b>  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE 13b. COUNTY 13c. CITY OR TOWN<br><b>Md. --- Baltimore</b>   |  |   |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> 13e. STREET ADDRESS<br><b>3940 Kenyon Avenue</b>            |  |  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>John Raither</b>  |  |   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Emma Rosenick</b>   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>No ---</b>  |  |   |  | 16b. SOCIAL SECURITY NO. 17. INFORMANT ADDRESS<br><b>212-34-9144 Mrs. Crystal McWilliams-3940 Kenyon Ave.</b>  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiorespiratory failure</b><br><b>5770</b> DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>pancreatitis (hemorrhagic)</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. }<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>---</b><br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a). |  |   |  |  |  |  |  |
| 19a. DATE OF OPERATION<br><b>2-17-82</b>  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>acute abdomen</b>                  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>                            |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                       |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>2/17</b> , 19 <b>82</b> , to <b>2/22</b> , 19 <b>82</b> , that (I) (we) last saw the deceased alive on <b>2/22</b> , 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |   |  |  |  |  |  |
| 22b. SIGNATURE<br><b>CC Max</b>   |  |   |  | DEGREE<br><b>U. MH</b>   |  | 22c. DATE SIGNED<br><b>2/22/82</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>CHRISTOPHER C. MAX</b>  |  |   |  | 22e. ADDRESS<br><b>U. MH</b>   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>2/25/82</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Oak Lawn Cemetery</b>   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>Baltimore, Maryland</b>  |  |
| 24. FUNERAL DIRECTOR NAME<br><b>John H. Moran, Inc.</b><br><b>3000 E. Baltimore St.</b><br><b>Baltimore, Md. 21224</b>  |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>FEB 26 1982</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>   |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. For retention by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral home, it should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH-16 30M 2/80  
(VRA 15, 4)

FOR  
1- STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |   |   |   |   |  |
|--|---|---|---|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>CLARENCE R. REIP   |   |   | 2a. DATE OF DEATH MONTH DAY YEAR<br>February 3, 1982                                      |   | 2b. HOUR<br>8:30 AM  |
| 3. SEX<br>Male   | 4. RACE<br>White  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>Sept. 10, 1907  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>74 YRS.  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.                                      |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>5415 Alameda |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Owner - Lunch Counter |   | 12b. KIND OF BUSINESS OR INDUSTRY  |
| 13a. STATE<br>Maryland   |   | 13b. COUNTY   | 13c. CITY OR TOWN<br>Baltimore  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS<br>5415 Alameda  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Clarence R. Reip   |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Elizabeth Hopkins                        |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No   |   | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>217 14 9152  |   | 17. INFORMANT ADDRESS<br>John E. Reip, 3821 Kimble Rd., Balto., Md.                             |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardiac arrest</u><br>4149<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Coronary heart disease</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a). |   |   |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |
| 19a. DATE OF OPERATION   |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK<br>NOT WHILE <input type="checkbox"/> AT WORK   |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>20 May</u> 19 <u>80</u> to <u>3 February</u> 19 <u>82</u> , that (I) <u>lost</u> saw the deceased alive on <u>1 February</u> 19 <u>82</u> , and that in (my) <u>best</u> opinion death occurred on the date and hour and from the causes stated above, (I) <u>yes</u> (did) <u>not</u> view the body after death.  |   |   |   |   |  |
| 22b. SIGNATURE<br><u>John W. Barnaby M.D.</u>  |   | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>        |   | 22c. DATE SIGNED<br><u>4 Feb 82</u>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Dr. John W. Barnaby, M.D.   |   | 22e. ADDRESS<br>1652 E. Belvedere Ave., Balto., Md.   |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial  |   | 23b. DATE<br>2/6/82   | 23c. NAME OF CEMETERY OR CREMATORY<br>Loudon Park   |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Balto., Md.  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Henry W. Jenkins & Sons Co.<br>4905 York Road Balto., Md. 21212  |   | 25a. DATE REC'D. BY REGISTRAR<br>FEB 4 1982   |   | 25b. REGISTRAR'S SIGNATURE<br><u>Thomas J. Martin</u>   |  |

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## References

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**References**

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...and a animal ...

2007-08-01 10:00 AM

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

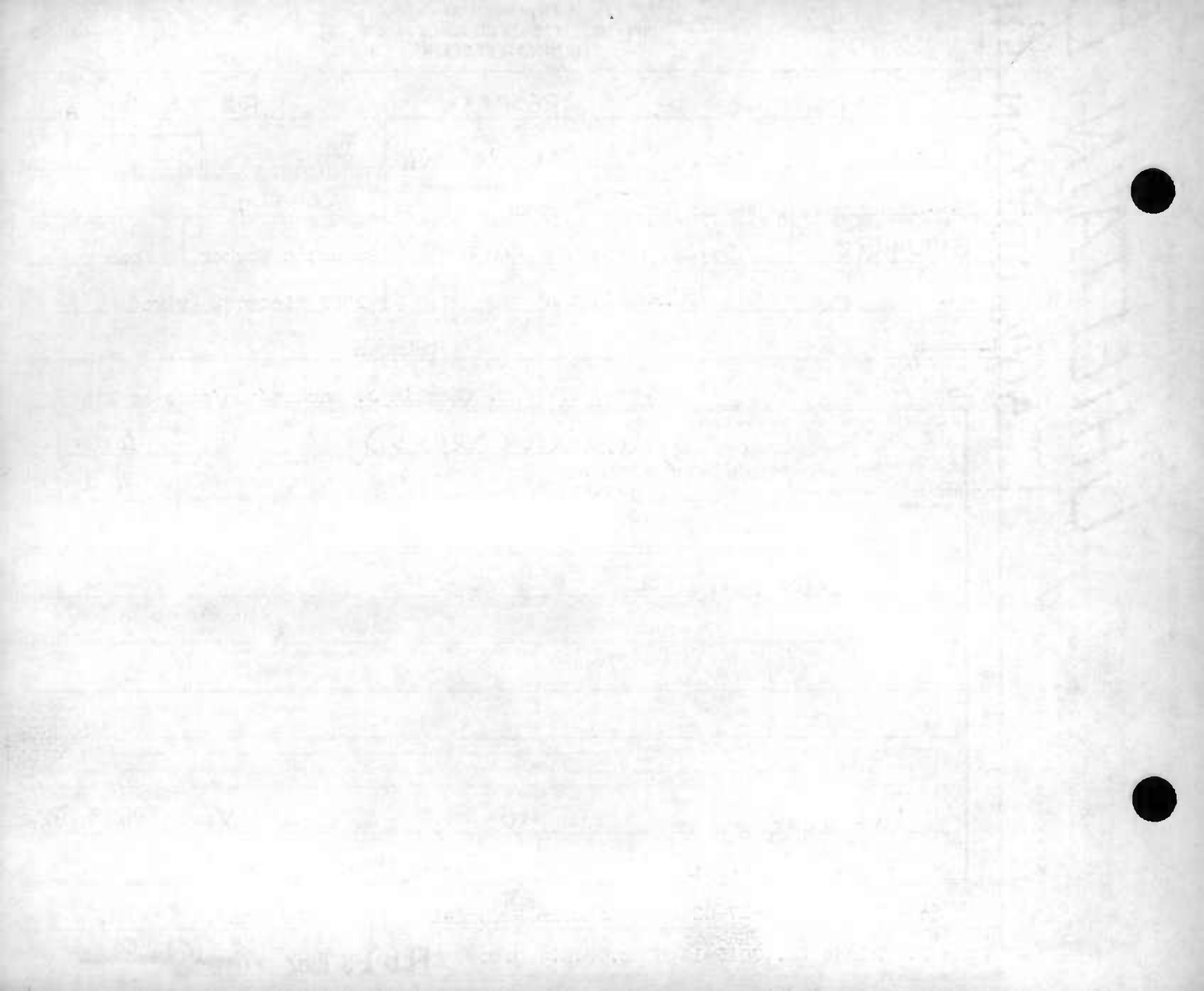
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  | REG. NO. 82 04136   |  |   |  |
|---|--|---|--|---|--|---|--|
| 1. FOR STATE REGISTRAR  |  |   |  |   |  |   |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>PAULINE M. RESPASS   |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR 2b. HOUR<br>Feb 13 1982 8:40 AM  |  |   |  |
| 3. SEX<br>Female  |  | 4. RACE<br>Black  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>Oct. 22 1898   |  | 6. AGE (IN YEARS LAST BIRTHDAY) 84 YRS.<br>IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.                      |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>N.C.   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>County Balto Cty MD   |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Sinai Hosp of Baltimore |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Domestic Worker  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>None   |  |
| 13a. STATE<br>Md.   |  | 13b. COUNTY<br>P.G.   |  | 13c. CITY OR TOWN<br>Ft. Washington   |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>Unknown  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Unknown   |  | 13e. STREET ADDRESS<br>2203 Piermont Drive  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>No   |  | 16b. SOCIAL SECURITY NO.<br>242-09-0407   |  | 17. INFORMANT ADDRESS<br>Mr. Charlie J. Barnes/son/same as 13e  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1: DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) 4860 Bacteremia (Sepsis)<br>DUE TO, OR AS A CONSEQUENCE OF (b) pneumonia<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost<br>DUE TO, OR AS A CONSEQUENCE OF (c)<br>PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br>Diabetes Mellitus |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>4 days<br>4 days  |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) lost saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |   |  |   |  |   |  |
| 22b. SIGNATURE<br>MING CHANG  |  | DEGREE<br>MD  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>       |  | 22c. DATE SIGNED<br>Feb. 13, 1982   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>MING CHANG   |  | 22e. ADDRESS<br>Sinai Hosp. of Baltimore  |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>Burial   |  | 23b. DATE<br>2-17-82  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Lincoln Memorial  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>Suitland, Md.  |  |
| 24. FUNERAL DIRECTOR<br>John T. Rhines Co., 3015 12th St., N.E., D.C.   |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br>FEB 19 1982  |  | 25b. REGISTRAR'S SIGNATURE<br>[Signature]   |  |

BP



DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

04137

1. FOR  
STATE  
REGISTRAR1. DECEASED NAME  
(TYPE OR PRINT)

FIRST

MIDDLE

LAST

CHARLES

REYNOLDS

2a. DATE KNOWN  
OF DEATH ESTI-  
MATED ☒ 2 11 1982 2b. HOUR  
M

3. SEX

male

4. RACE

negro

5. DATE OF BIRTH  
MONTH DAY YEAR

10

15

32

6. AGE (IN YEARS  
LAST BIRTHDAY)  
YRS.

50

IF UNDER 1 YR.

MONTHS

DAYS

IF UNDER 24 HRS.

HOURS

MIN.

7c. DATE  
PRONOUNCED  
DEAD 2 12 1982 2d. HOUR  
a M7a. BIRTHPLACE (STATE OR  
FOREIGN COUNTRY)

BALTIMORE

7b. CITIZEN OF WHAT COUNTRY?

USA

8. MARRIED ☐ NEVER MARRIED ☐  
WIDOWED ☐ DIVORCED ☒

9. BALTIMORE CITY OR COUNTY OF DEATH

Baltimore City

MD.

10. CITY OR TOWN OF DEATH

Baltimore

11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION  
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)

707 Mura St.

12a. USUAL OCCUPATION (TYPE OF WORK  
FOR MOST OF WORKING LIFE)12b. KIND OF BUSINESS  
OR INDUSTRY

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE

MD.

13b. COUNTY

13c. CITY OR TOWN

BALTIMORE

13d. INSIDE CITY LIMITS?

YES ☒ NO ☐

13e. STREET ADDRESS

707 MURA ST.

14. FATHER'S NAME

CHARLES

MIDDLE

LAST

REYNOLDS, SR.

15. MOTHER'S MAIDEN NAME

FIRST

IDA

MIDDLE

LAST

SHELTON

16a. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(YES, NO, OR UNKNOWN)  
YES

(IF YES, GIVE WAR OR DATES)

16b. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

MARGIE PICKETT

2021 BEECHWOOD

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY:

2762

IMMEDIATE CAUSE (a) Hyperglycemic keto-acidosis

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which  
gave rise to immediate  
cause (a) stating the under-  
lying cause lost.(b) \_\_\_\_\_  
DUE TO, OR AS A CONSEQUENCE OF

(c) \_\_\_\_\_

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?

20. AUTOPSY?

YES ☒ NO ☐

21a. EXTERNAL CAUSE WAS

UNDERLYING ☐ OR  
CONTRIBUTING ☐ CAUSE OF DEATH21b. TIME OF INJURY  
HOUR A.M. MONTH DAY YEAR  
P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d. INJURY OCCURRED

WHILE ☐ NOT WHILE ☐  
AT WORK AT WORK21e. PLACE OF INJURY (AT HOME,  
STREET, FACTORY, FARM, ETC.)

21f. LOCATION

STREET

CITY OR TOWN

COUNTY

STATE

22a. I certify that I took charge of the remains described above, held on Autopsy ☒ Inspection ☐ Inquiry ☐ and in my opinion  
death resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE

TITLE (SPECIFY)

M.D. Assistant MEDICAL EXAMINER

DATE  
SIGNED 2-12-82EXAMINER'S NAME  
(TYPE OR PRINT)

Ann M. Dixon, M.D.

ADDRESS 111 Penn St.

23a. BURIAL, CREMATION, REMOVAL  
(SPECIFY)

BURIAL

23b. DATE

2/17/82

23c. NAME OF CEMETERY OR CREMATORY

KING MEMORIAL PARK

23d. LOCATION  
CITY OR TOWN

Baltimore Co. Md.

COUNTY

STATE

24. FUNERAL DIRECTOR

NAME

ADDRESS

WM. C. MARCH F/H 1101 E. NORTH AVENUE

25a. DATE REC'D. BY REGISTRAR

FEB 16 1982

25b. REGISTRAR'S SIGNATURE

Theresa Jan North

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE  
EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR.  
PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PW 3. RETAIN PAGE 5 FOR YOUR FILES.  
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS  
AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST.,  
BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.BP  
DHMH-17  
(VR A15 ME (5))  
15M 2/80

(21)

WALTON

WALTON

WALTON

WALTON

WALTON

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WALTON

WALTON

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WALTON

WALTON

WALTON

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |   |  |  |  |  |   |
|--|--|--|--|---|--|--|--|--|---|
| 1- FOR STATE REGISTRAR   |  |  |  |   | REG. NO.   |  |  |  |   |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br><b>Charles F. Rheulotton</b>   |  |  |  |   | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>2/3/82</b>  |  |  | 2b. HOUR<br><b>2:38 AM</b>   |   |
| 3 SEX<br><b>MALE</b>   |  | 4 RACE<br><b>BLACK</b>   |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>10 14 64</b>  |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>17</b>  |  | IF UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 24 HRS. HOURS MIN.   |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland, USA</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.                            |  |  |   |
| 10 CITY OR TOWN OF DEATH<br><b>Baltimore</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>University of Maryland Hospital</b> |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>High School Student</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |   |
| 13a. STATE<br><b>Maryland</b>  |  | 13b. COUNTY<br><b>Baltimore</b>  |  | 13c. CITY OR TOWN<br><b>Baltimore</b>   |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>818 N. Amity Street</b>  |   |
| 14 FATHER'S NAME FIRST MIDDLE LAST<br><b>Frank Y. Rheulotton</b>   |  |  |  |   | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Lillian NMI Williams</b>  |  |  |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><b>NO</b>   |  | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)<br><b>NONE</b>  |  | 17 INFORMANT ADDRESS<br><b>Hospital Records.</b>  |  |  |  |  |   |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiac Arrest</b><br><b>4210</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>Congestive Heart failure</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>Bacterial Endocarditis/Aortic Valveular Disease</b> |  |  |  |   |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>2:38 AM 2/3/82</b><br><b>1/28/82</b><br><b>1/23/82</b> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a  |  |  |  |   |  |  |  |  |   |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |  | 20a. AUTOPSY? Decision Pending<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |  |   |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |  |  |  |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>Jan 23</b> , 19 <b>82</b> , to <b>Feb 3</b> , 19 <b>82</b> , that (I) (we) lost<br>saw the deceased alive on <b>Feb 3</b> , 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.   |  |  |  |   |  |  |  |  |   |
| 22b. SIGNATURE<br><b>E. Pritchett M.D.</b>   |  |  |  |   | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  |  | 22c. DATE SIGNED<br><b>2/3/82</b>  |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>E. Pritchett, M.D.</b>   |  |  |  |   | 22e. ADDRESS<br><b>Dept Pediatrics, University Hospital 22 S. Greene St</b>  |  |  |  |   |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>2-6-82</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>White Rock Cemetery</b>  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>Shawville Carroll Md</b>                       |  | 25a. DATE REC'D BY REG. CLERK 25b. REGISTRAR'S SIGNATURE   |   |
| 24. FUNERAL DIRECTOR NAME<br><b>Harry W. Haight</b>  |  |  |  |   | ADDRESS<br><b>Shawville, Md.</b>   |  |  |  |   |





NOT TO BE REPRODUCED

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be called at once.

DHMH - 16 50M 1/81  
(VRA 15, 4)

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  |   |  |   |  |   |  | REG. NO. 82 04139                            |  |
|--|--|---|--|---|--|---|--|---|--|--|--|
| 1. FOR STATE REGISTRAR   |  | 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br><b>BURNETT L. RIES</b>  |  |   |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>FEB. 5/1982</b>  |  | 2b. HOUR<br><b>2:30 AM</b>                   |  |
| 3. SEX<br><b>Male</b>  |  | 4. RACE<br><b>White</b>   |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>March 12, 1908</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY) YRS<br><b>73</b>                                  |  | 7. IF UNDER 1 YEAR MONTHS DAYS<br><b></b>   |  | 7b. IF UNDER 24 HRS. HOURS MIN.<br><b></b>   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.                 |  |   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN FACILITY, GIVE STREET ADDRESS)<br><b>Bon Secours Hospital</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK OR MOST OF WORKING LIFE)<br><b>Welder</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Fabrication</b>   |  |  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE<br><b>Maryland</b>   |  | 13c. CITY OR TOWN<br><b>Balto.</b>  |  | 13d. INSIDE CITY LIMITS? NO <input checked="" type="checkbox"/>   |  | 13e. STREET ADDRESS<br><b>125 Garden Ridge Road</b>                               |  |   |  |  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>Frederick Jacob RIES</b>   |  |   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Louisa Anna Schultheis</b>   |  |   |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><b>no</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>212-07-2168</b>  |  | 17. INFORMANT<br><b>Loretta M. RIES</b>   |  |   |  | ADDRESS<br><b>same as above</b>   |  |  |  |
| 18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Chronic Congestive Heart Failure</b><br><b>4241</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>Aortic Stenosis / insufficiency (trans)</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO, OR AS A CONSEQUENCE OF (c) <b>Chronic obstructive lung disease</b> |  |   |  |   |  |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a)<br><b>Hypertensive Atherosclerotic Cardiovascular Disease</b>   |  |   |  |   |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION<br><b>Feb 5</b>   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b></b>   |  |   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)<br><b></b>   |  |   |  |   |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)<br><b></b>  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE<br><b></b>   |  |   |  |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>Jan 26</b> 19 <b>82</b> , to <b>Feb 5</b> 19 <b>82</b> , that (I) (we) last saw the deceased alive on <b>Feb 5</b> 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |   |  |   |  |   |  |   |  |  |  |
| 22b. SIGNATURE<br><b>Bernardo D. Gonzalez</b>  |  |   |  | DEGREE<br><b>MD</b>   |  |   |  | 22c. DATE SIGNED<br><b>Feb 5/82</b>   |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>BERNARDO D. GONZALEZ</b>   |  |   |  | 22e. ADDRESS<br><b>BON SECOURS HOSP, BALTO, MD</b>  |  |   |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Cremation</b>  |  | 23b. DATE<br><b>2/6/1982</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Westview Mem. Pk.</b>  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>Catonsville, Balto, Md.</b>         |  |   |  |  |  |
| 24. FUNERAL DIRECTOR NAME<br><b>Raymond C. Fink</b>  |  |   |  | ADDRESS<br><b>Glen Burnee, Md.</b>  |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>FEB 8 1982</b>  |  |  |  |
|  |  |   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Frances Jan...</b>   |  |   |  |   |  |  |  |

MEDICAL CERTIFICATION



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH-17  
(VR A15 ME (5))  
15M 2/80

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

|  |                  |  |  |   |                               |   |  |   |                  |
|--|------------------|--|--|---|-------------------------------|---|--|---|------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Thomas Riggs  |                  |  |  | 2a. DATE KNOWN OF DEATH<br>ESTIMATED <input checked="" type="checkbox"/> 2 21 1982  |                               |   |  | 2b. HOUR<br>M 5:52 A. M   |                  |
| 3. SEX<br>Male   | 4. RACE<br>Black | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>4 7 00   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>81 YRS. | IF UNDER 1 YR.<br>MONTHS DAYS   | IF UNDER 24 HRS.<br>HOURS MIN | 2c. DATE PRONOUNCED DEAD<br>2 21 1982   |  |   | 2d. HOUR<br>A. M |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MD  |                  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                               | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City, MD.                                     |  |   |                  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore   |                  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>1013 Bennett Place |  |   |                               | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                                   |  | 12b. KIND OF BUSINESS OR INDUSTRY   |                  |
| 13a. STATE<br>MD   |                  | 13b. COUNTY  |  | 13c. CITY OR TOWN<br>Baltimore  |                               | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br>1013 Bennett Place   |                  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>— — —  |                  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>— — —  |                               |   |  |   |                  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br>No  |                  | (IF YES, GIVE WAR OR DATES)  |  | 16b. SOCIAL SECURITY NO.<br>225-05-3446   |                               | 17. INFORMANT ADDRESS<br>Annie Woods 1013 Bennett Place   |  |   |                  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1 DEATH WAS CAUSED BY:<br>4292 IMMEDIATE CAUSE (a) Arteriosclerotic Cardiovascular Disease<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last:<br>(b) _____<br>(c) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>DUE TO, OR AS A CONSEQUENCE OF  |                  |  |  |   |                               |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |                  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).  |                  |  |  |   |                               |   |  |   |                  |
| 19a. DATE OF OPERATION   |                  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |                               |   |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |                  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |                               |   |  |   |                  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |                  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |                               |   |  |   |                  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . |                  |  |  |   |                               |   |  |   |                  |
| ACTUAL SIGNATURE Virginia L. Dolan   |                  |  |  | TITLE (SPECIFY)<br>M.D. Assistant   |                               | MEDICAL EXAMINER  |  | DATE SIGNED 2-21-82   |                  |
| EXAMINER'S NAME (TYPE OR PRINT) Virginia L. Dolan, M.D.  |                  |  |  | ADDRESS 111 Penn Street   |                               |   |  |   |                  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial  |                  | 23b. DATE<br>2/26/82   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Mt. Zion Cemetery   |                               | 23d. LOCATION<br>CITY OR TOWN Baltimore   |  | COUNTY STATE<br>MD  |                  |
| 24. FUNERAL DIRECTOR<br>NAME Wm. C. March F/H ADDRESS 1101 E. North Ave.   |                  |  |  | 25a. DATE REC'D. BY REGISTRAR<br>FEB 26 1982  |                               | 25b. REGISTRAR'S SIGNATURE<br>Thomas J. Nathan  |  |   |                  |

1601

entirely correct

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the State Department of Health and Mental Hygiene prior to burial, cremation, or removal.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Department of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: This form is marked with "18" in the top right corner. If the medical examiner must be notified, the medical examiner must be notified.

RELEASED ON APPROVAL BY THE MEDICAL EXAMINER.

MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |   |  |   |  |   |   |  |
|--|--|--|---|--|---|--|---|---|--|
| 1. FOR STATE REGISTRAR   |  |  |   |  |   |  |   |   |  |
| REG. NO.   |  |  |   |  |   |  |   |   |  |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br>TIMOTHY J. RIPPLE  |  |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>2 1 82  |  |   |   |  |
| 3 SEX<br>MALE  |  |  |   |  | 4 RACE<br>WHITE   |  |   |   |  |
| 5 DATE OF BIRTH MONTH DAY YEAR<br>02 22 60   |  |  |   |  | 6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS HOURS MIN<br>21 YRS.  |  |   |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MARYLAND  |  |  |   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  |   |   |  |
| 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>   |  |  |   |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.   |  |   |   |  |
| 10 CITY OR TOWN OF DEATH<br>BALTIMORE  |  |  |   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>BALTIMORE CITY HOSPITAL |  |   |   |  |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>TRAILER MECHANIC  |  |  |   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>TRANSPORT  |  |   |   |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. CITY OR TOWN<br>MARYLAND BALTIMORE   |  |  |   |  | 13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                      |  |   |   |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>JAMES RIPPLE  |  |  |   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>MARJORIE MATHIAS  |  |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>NO  |  |  |   |  | 16b. SOCIAL SECURITY NO<br>216-76-1683  |  |   |   |  |
| 17 INFORMANT ADDRESS<br>DEBORAH L. RIPPLE 4101 OLD WASHINGTON BLVD.  |  |  |   |  |   |  |   |   |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) SEPSIS<br>8940<br>DUE TO, OR AS A CONSEQUENCE OF (b) 55% total body surface burn<br>DUE TO, OR AS A CONSEQUENCE OF (c) Cardiovascular arrest<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>2 days |  |  |   |  |   |  |   |   |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br>respiratory insufficiency  |  |  |   |  |   |  |   |   |  |
| 19a. DATE OF OPERATION<br>12/3/81  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br>Burns                     |  |   | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                    |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)<br>WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>2 P.M. 12 3 1981              |  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)<br>gasoline fire burn |   |   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)<br>at job |  |   | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE<br>unknown  |   |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 12/3 1981, to 2/1 1982, that (I) (we) last saw the deceased alive on 2/1 1982, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                         |  |  |   |  |   |  |   |   |  |
| 22b. SIGNATURE<br>MCFADDEN   |  |  |   |  | 22c. DATE SIGNED<br>2/1/82  |  |   |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>MCFADDEN  |  |  |   |  | 22e. ADDRESS<br>532 A N. Bond St Balt Md 21205  |  |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>BURIAL  |  |  | 23b. DATE<br>02-04-82   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>MEADOWRIDGE MEM. PK.  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>ELKRIDGE HOWARD MARYLAND |   |  |
| 24 FUNERAL DIRECTOR NAME<br>HUBBARD FUNERAL HOME, INC. 4107 WILKENS AVE.   |  |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br>FEB 5 1982   |  | 25b. REGISTRAR'S SIGNATURE<br>Charles Van Natten                    |   |  |



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Items #3&amp;17 Film G565 3/1/82 rc

STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2

0 4 1 4 2

FOR  
STATE  
REGISTRAR

REG. NO.

|   |   |   |   |  |   |   |
|---|---|---|---|--|---|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Minna N. Ritter</b>   |   |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>February 21, 1982</b>       |  | 2b. HOUR<br><b>12 noon</b>  |   |
| 3. SEX<br><b>Female</b>   | 4. RACE<br><b>White</b>   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Feb. 14, 1895</b>  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>87</b> YRS.  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN                                  |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.  |   |   |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Hamilton Nursing Home</b> |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Homemaker</b>   |   |   |
| 13a. STATE<br><b>Maryland</b>   |   |   | 13b. COUNTY   | 13c. CITY OR TOWN<br><b>Baltimore</b>  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Olaf</b>   |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Sophia Martin</b> |  |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>   |   | 16b. SOCIAL SECURITY NO.  |   | 17. INFORMANT<br><b>Son: Nelson F. Ritter</b> ADDRESS<br><b>Arlington, Va. 3608 36th Road N 22207</b>                                      |   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>ASCVD - CHF - acute MI</b><br>2500<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Diabetes mellitus - insulin dep</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Dementia due to stroke</b><br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>old hyp &amp;</b> |   |   |   |  |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH   |
| 19a. DATE OF OPERATION  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |   |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |   | 21e. PLACE OF INJURY<br>(AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |   |   |
| 22a. I certify that (I) this hospital attended the deceased from <b>Feb 1</b> , 19 <b>78</b> , to <b>Feb 21</b> , 19 <b>82</b> , that (I) (we) last saw the deceased alive on <b>Feb 10</b> , 19 <b>82</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |   |   |   |  |   | 22c. DATE SIGNED<br><b>2/22/82</b>  |
| 22b. SIGNATURE<br><b>Donald W. Mintzer MD</b>   |   | DEGREE  |   | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   | 22e. ADDRESS<br><b>3009 Evergreen Ave. Balt., Md. 21214</b>   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Dr. Donald W. Mintzer M.D.</b>  |   |   |   |  |   |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   | 23b. DATE<br><b>Feb 24 1982</b>   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Oak Lawn Cemetery</b>  |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Maryland</b>  |   |   |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Leonard J. Ruck, Inc. Baltimore, Maryland</b>  |   |   |   | 25a. DATE REC'D. BY REGISTRAR<br><b>FEB 24 1982</b>  |   |   |
|   |   |   |   | 25b. REGISTRAR'S SIGNATURE<br><i>Thomas J. [Signature]</i>   |   |   |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified by a physician.

1974

February 21, 1982

Letter

F.

James

1974

1980, 10, 1982

White

White

1974, 10, 1982

X

U.S.A.

1974, 10, 1982

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1974, 10, 1982

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 4 1 4 3

REG. NO.

|   |   |   |   |  |   |
|---|---|---|---|--|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Joseph H. Roberts</b>   |   |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>February 3, 1982</b>          |  | 2b. HOUR<br><b>9:25p</b> M  |
| 3. SEX<br><b>Male</b>   | 4. RACE<br><b>Black</b>   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>9 10 09</b>  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>72</b> YRS.  |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Charleston, SC</b>  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.  |   |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>MARYLAND GENERAL HOSPITAL</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)        |  | 12b. KIND OF BUSINESS OR INDUSTRY   |
| 13a. STATE<br><b>MD</b>   |   |   | 13b. COUNTY   | 13c. CITY OR TOWN<br><b>Baltimore</b>  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>George Roberts</b>   |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Cecelia Roberts</b> |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>No</b>   |   | 16b. SOCIAL SECURITY NO.<br><b>N/A</b>  |   | 17. INFORMANT ADDRESS<br><b>Alice A. Roberts 2018 Madison Ave.</b>   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Pneumonia</b><br>8809<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(b) <b>Debilitated State Secondary to Subdural Hematoma,</b><br>(c) <b>Intracerebral Hemorrhage,</b> |   |   |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>3 days</b><br><b>16 days</b><br><b>16 days</b> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>Dehydration, Atelectasis</b>  |   |   |   |  |   |
| 19a. DATE OF OPERATION  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                       |   |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |   |   |   |  |   |
| 21a. ACCIDENT WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 21b. TIME OF INJURY<br>HOUR MONTH DAY YEAR<br><b>7:30 P.M. 1-18- 1982</b>   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)<br><b>Fell down stairs.</b> |   |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)<br><b>home</b>   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br><b>2018 Madison Ave., Balto. Md.</b>                  |   |
| 22a. I certify that (X) (this hospital) attended the deceased from <b>January 19, 1982</b> , to <b>February 3, 1982</b> , that (I) (we) last saw the deceased alive on <b>February 3, 1982</b> , and that in (my) (our) opinion death occurred on the day and hour and from the causes stated above, (I) (we) (did) (do not) view the body after death.           |   |   |   |  |   |
| 22b. SIGNATURE<br><b>Janice Rutkowski, M.D.</b>   |   | DEGREE<br><b>M.D.</b>   |   | 22c. DATE SIGNED   |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Janice Rutkowski, M.D.</b>  |   | 22e. ADDRESS<br><b>C/O Maryland General Hospital</b>  |   |  |   |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |   | 23b. DATE<br><b>2/8/82</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Arbutus Mem. Pk.</b>  |   |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Arbutus MD</b>   |   |   |   |  |   |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Wm. C. March F/H, Inc.</b>   |   | ADDRESS<br><b>1101 E. North Ave.</b>  |   | 25a. DATE REC'D. BY REGISTRAR<br><b>FEB 8 1982</b>   |   |
| 25b. REGISTRAR'S SIGNATURE<br><b>Frances Jan Nathan</b>   |   |   |   |  |   |

SECRET

508 1025 8 65

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 4 1 4 4

REG. NO.

|  |   |   |   |  |  |
|--|---|---|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>William O. Roberts  |   |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>February 10, 1982                    |  | 2b. HOUR<br>7 05 P.M.  |
| 3. SEX<br>Male   | 4. RACE<br>White  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>April 5, 1921   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>60 YRS.   | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Penna   | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.                           |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>2714 Strathmore Ave. (Residence) |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Printer | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13a. STATE<br>Maryland   |   |   | 13b. COUNTY   | 13c. CITY OR TOWN<br>Baltimore   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>James Roberts  |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Elva Orndorf               |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>Yes  |   | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>WW II Army 078-07-1280   |   | 17. INFORMANT Wife:<br>Alice B. Roberts 2714 Strathmore Ave.                         |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Metastatic Ca of the esophagus</u><br>1509 } DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>(c) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |   |   |   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)   |   |   |   |  |  |
| 19a. DATE OF OPERATION   |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>  |   | 21e. PLACE OF INJURY<br>(AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |
| 22. I certify that (1) (this hospital) attended the deceased from <u>6/30</u> , 19 <u>81</u> , to <u>2/10</u> , 19 <u>82</u> , that (1) (we) last saw the deceased alive on <u>12/17</u> , 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) (did) (did not) view the body after death.           |   |   |   |  |  |
| 22b. SIGNATURE<br>ELM  |   | DEGREE  |   | 22c. DATE SIGNED<br>2/11/82  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Dr. Nagel & Robbins, P.A.   |   | 22e. ADDRESS<br>1205 York Rd.   |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial   |   | 23b. DATE<br>Feb 13 1982  | 23c. NAME OF CEMETERY OR CREMATORY<br>Parkwood Cemetery                     |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore Maryland   |
| 24. FUNERAL DIRECTOR<br>NAME<br>Leonard J. Ruck, Inc. 5305 Harford Rd. Balto. Md.  |   | 25a. DATE REC'D. BY REGISTRAR<br>FEB 11 1982  |   | REGISTRAR'S SIGNATURE<br>Thomas J. [Signature]                                       |  |

102

April 3, 1951

White

Male

X

Baltimore City

W.A.A.

Female

2114 Baltimore Ave. (Residence)

Baltimore

April 3, 1951

2114 Baltimore Ave.

Baltimore

Female

Robert

White

Robert

Male

April 3, 1951

2114 Baltimore Ave.

2114 Baltimore Ave.

Yes



APR 11 1951  
FEB 11 1951  
Baltimore

APR 11 1951



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 50M 1/81  
(VRA 15, 4)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 4 1 4 5

FOR  
STATE  
REGISTRAR

REG. NO.

|  |   |   |   |  |  |
|--|---|---|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>Agnes E. Robinson</b>   |   |   | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>February 3, 1982</b>                                     |  | 2b. HOUR<br><b>7:50p M</b>   |
| 3. SEX<br><b>Female</b>  | 4. RACE<br><b>White</b>   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>3-27-1912</b>  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>69</b> YRS.   | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.<br>IF UNDER 24 HRS.                        |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Baths, Ind.</b>  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City MD.</b>                               |  |  |
| 11. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Maryland General Hospital</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Seamstress</b>           |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Washers Factory</b>  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>Ind.</b>  |   | 13b. COUNTY<br><b>Baltimore</b>   | 13c. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS<br><b>907 W. Barre St. 21230</b>                                 |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>John J. Gallagher</b>   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Agnes Scullen</b>   |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>  |   | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>212-05-9500A</b>  |   | 17. INFORMANT<br>ADDRESS<br><b>Tracy P. Vinci 1926 Deering Ave. 21230</b>            |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Myocardial Ischemic Episode</b><br><b>4100</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Congestive Heart Failure</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)   |   |   |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>Minutes</b>   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a)<br><b>Coronary Artery Disease</b>   |   |   |   |  |  |
| 19a. DATE OF OPERATION   |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)       |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |
| 22a. I certify that (b) (this hospital) attended the deceased from <b>January 30</b> , 19 <b>82</b> , to <b>February 3</b> , 19 <b>82</b> , that (we) lost saw the deceased alive on <b>February 3</b> , 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (b) (we) (did) (do not) view the body after death. |   |   |   |  |  |
| 22b. SIGNATURE<br><b>Dr. Garney MD</b>   |   | DEGREE  |   | 22c. DATE SIGNED<br><b>2/4/82</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Joseph Garney, M.D.</b>  |   | 22e. ADDRESS<br><b>C/O Maryland General Hospital</b>  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>burial</b>  |   | 23b. DATE<br><b>2-6-1982</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>New Catholic Cem.</b>                       |  |
| 23d. LOCATION<br>(CITY OR TOWN)<br><b>Baltimore</b>  |   | COUNTY<br><b>Ind.</b>   |   | STATE  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>John J. Cowan &amp; Son, Inc.</b>   |   | ADDRESS<br><b>Baths, Ind. 21223</b>   |   | 25a. DATE REC'D. BY REGISTRAR<br><b>FEB 5 1982</b>                                   |  |
| 25b. REGISTRAR'S SIGNATURE<br><b>James J. [Signature]</b>  |   |   |   |  |  |



(M)

Virginia General Hospital

Neurological Institute

Comprehensive Health Services

Community Health Services



Virginia General Hospital

Neurological Institute

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of same.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  |  |  |   |  |  |  |
|---|--|---|--|--|--|---|--|--|--|
| 1. FOR STATE REGISTRAR  |  | REG. NO.  |  |  |  | 8204146   |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT) <u>ROBINSON</u>  |  | MIDDLE <u>CLARENCE</u>  |  | 2a. DATE OF DEATH MONTH DAY YEAR <u>02/22/82</u>   |  | 2b. HOUR <u>M</u>   |  |  |  |
| 3. SEX <u>MALE</u>  |  | 4. RACE <u>BLACK</u>  |  | 5. DATE OF BIRTH MONTH DAY YEAR <u>09 25 01</u>  |  | 6. AGE (IN YEARS LAST BIRTHDAY) <u>80</u> YRS   |  | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>MD.</u>  |  | 7b. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <u>BALTO. CITY</u> MD.   |  |  |  |
| 10. CITY OR TOWN OF DEATH <u>BALTO.</u>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>LAFAYETTE SQUARE NURSING CENTER</u> |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)   |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  | 13a. STATE <u>MD.</u>   |  | 13b. COUNTY <u>BALTO.</u>  |  | 13c. CITY OR TOWN <u>BALTO.</u>   |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST <u>GEORGE ROBINSON</u>  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <u>LAVENIA BORDERLY</u>  |  | 13e. STREET ADDRESS <u>140 W. CAFEYETTE AVE</u>  |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>NO</u>   |  | 16b. SOCIAL SECURITY NO. <u>220-09-2202</u>   |  | 17. INFORMANT <u>Mildred Robinson Westminster, Md</u>  |  |   |  |  |  |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <u>4029 HASCD - ventricular Arrhythmia</u><br>DUE TO, OR AS A CONSEQUENCE OF (b) _____<br>DUE TO, OR AS A CONSEQUENCE OF (c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.  |  |   |  |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Many years</u>                               |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a)<br><u>① CVA ② UTI ③ Decubitus ulcers</u>  |  |   |  |  |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <u>19</u>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |   |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY (AT HOME STREET FACTORY, OFFICE, FARM, ETC.)   |  | 21i. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>2-17-82</u> 19 <u>82</u> to <u>2-22-82</u> 19 <u>82</u> , that (I) (we) last saw the deceased alive on <u>2-22-82</u> 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |  |  |  |   |  |  |  |
| 22b. SIGNATURE <u>SHANK AT Y. K. HAN</u> MD   |  | DEGREE  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>               |  | 22c. DATE SIGNED <u>2-22-82</u>   |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>SHANK AT Y. K. HAN</u>   |  | 22e. ADDRESS <u>1528 King William Ave, Balto, MD</u>  |  |  |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>   |  | 23b. DATE <u>2-24-82</u>  |  | 23c. NAME OF CEMETERY OR CREMATORY <u>Western Chapel</u>   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE <u>Westminster Carroll MD</u>   |  |  |  |
| 24. FUNERAL DIRECTOR <u>Robert Kyle Pittman Jr. Westminster, Md.</u>  |  | 25a. DATE REC'D. BY REGISTRAR <u>MAR 1 1982</u>   |  | 25b. REGISTRAR'S SIGNATURE <u>Thom...</u>  |  |   |  |  |  |



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DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

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FOR  
1 - STATE  
REGISTRAR

REG. NO.

|  |   |   |   |  |   |
|--|---|---|---|--|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>WELFORD C. ROBINSON</b>   |   |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>FEBRUARY 6, 1982</b>                            |  | 2b. HOUR<br><b>9:40 A.M.</b>  |
| 3. SEX<br><b>M.</b>  | 4. RACE<br><b>NEGRO</b>   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>9 14 1900</b>  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>81</b><br>MONTHS DAYS HOURS MIN.         |   |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br><b>VA.</b>   | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Balt. City</b> MD.                  |   |
| 10. CITY OR TOWN OF DEATH<br><b>Balto.</b>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NO IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Thornport Hosp</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Crane Operator</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Beth Steel</b>  |
| 13a. STATE<br><b>MD</b>  |   |   | 13b. COUNTY<br><b>BALTO</b>   | 13c. CITY OR TOWN<br><b>BALTO</b>  |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Edward Robinson</b>   |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>?</b>                                 |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>NO</b>  |   |   | 16b. SOCIAL SECURITY NO.<br><b>216-10-4233</b>  |  |   |
| 17. INFORMANT<br><b>Rev. Minnie B. Robinson</b>  |   |   | ADDRESS<br><b>2325 Bryant Ave</b>   |  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARDIAC ARRHYTHMIA</b><br><b>1629</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(b) <b>RESPIRATORY INSUFFICIENCY</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>SQUAMOUS CELL CARCINOMA LUNG</b> |   |   |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>MINUTES</b><br><b>MINUTES</b><br><b>MONTHS</b> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:<br><b>CHRONIC BRONCHITIS</b>  |   |   |   |  |   |
| 19a. DATE OF OPERATION   |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>      |   |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |   |   |   |  |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>FEB. 6</b> , 19 <b>82</b> , to <b>FEB. 6</b> , 19 <b>82</b> , that I (we) last saw the deceased alive on <b>FEB. 6</b> , 19 <b>82</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |   |   |   |  |   |
| 22b. SIGNATURE<br><b>Donald R. Ware M.D.</b>   |   | DEGREE<br><b>M.D.</b>   |   | 22c. DATE SIGNED<br><b>2/6/82</b>  |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>DONALD R. WARE, M.D.</b>   |   | 22e. ADDRESS<br><b>PROVIDENT HOSPITAL</b>   |   |  |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY) <b>Burial</b>   |   | 23b. DATE<br><b>2/10/82</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Int. Cemetery</b>                     |   |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>B. &amp; O. Country, MD</b>   |   |   |   |  |   |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Rock's Funeral Home 1304 N. Central Ave</b>   |   | 25a. DATE RECD. BY REGISTRAR<br><b>FEB 8 1982</b>   |   | 25b. REGISTRAR'S SIGNATURE<br><b>Thomas J. [Signature]</b>                     |   |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 4 1 4 8

1. FOR  
STATE  
REGISTRAR

REG. NO.

|  |  |  |  |   |                                      |  |  |
|--|--|--|--|---|--------------------------------------|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Shirley Rodbell</b>   |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>2 3 82</b> |   | 2b. HOUR<br><b>5:40A<sub>M</sub></b> |  |  |
| 3. SEX<br><b>FEMALE</b>  |  | 4. RACE<br><b>Cauc</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>12 25 04</b>   |                                      | 6. AGE (IN YEARS LAST BIRTHDAY)<br>MONTHS DAYS HOURS MIN.<br><b>77</b> YRS.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>ENGLAND</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>US</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                      | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>City</b> MD.  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore City</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Sinai Hospital</b> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>HOUSEWIFE</b>  |                                      | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>AT HOME</b>  |  |
| 13a. STATE<br><b>MD</b>  |  | 13b. COUNTY<br><b>Balt</b>   |  | 13c. CITY OR TOWN<br><b>Balt</b>  |                                      | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  |
| 13e. STREET ADDRESS<br><b>3017 Romer Ct</b>  |  | 13f. APT. 1-1 #21209   |  | 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>UNKNOWN ABRAMS</b>   |                                      | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>UNKNOWN</b>  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>2 13 606490</b>   |  | 17. INFORMANT<br><b>MRS. JUDITH RISBERG</b>   |                                      | ADDRESS<br><b>7205 BROOK CREST WAY., APT. B-3 #21208</b>   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Septic Shock</b><br><b>0389</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) <b>Overwhelming sepsis</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>WKS</b> |  |  |  |   |                                      |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:<br><b>Existing antequagants, CVA, Acute coronary insufficiency, Probable SBE</b>  |  |  |  |   |                                      |  |  |
| 19a. DATE OF OPERATION<br><b>12/3/81</b>   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>cholecystectomy for gangrenous cholecystitis</b>                            |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                                      | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B. PART 1 OR PART 2)  |                                      |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |                                      |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>Jan 18</b> , 19 <b>82</b> , to <b>Feb 3</b> , 19 <b>82</b> , that (I) (we) lost<br>saw the deceased alive on <b>Feb 3</b> , 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.   |  |  |  |   |                                      |  |  |
| 22b. SIGNATURE<br><b>Wendy Kellner</b>   |  | DEGREE   |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>                  |                                      | 22c. DATE SIGNED<br><b>Feb 3/82</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Wendy Kellner</b>  |  | 22e. ADDRESS<br><b>SINAI HOSP. - BALTO., MD</b>  |  |   |                                      |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY) <b>BURIAL</b>   |  | 23b. DATE<br><b>FEB. 4, 1982</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>AITZ CHAIM</b>   |                                      | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>BALTIMORE MARYLAND</b>  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>SOL LEVINSON &amp; BROS., INC.</b><br><b>6010 REISTERSTOWN RD. BALTO., MD 21215</b>   |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>FEB 11 1982</b>   |                                      |  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Handwritten notes and signatures, including a large signature at the bottom left.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  |   |  |  |  |   |  |   |  |
|---|--|--|--|---|--|--|--|---|--|---|--|
| 1. FOR<br>STATE<br>REGISTRAR  |  | REG. NO.   |  |   |  | 8204149  |  |   |  |   |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  | FIRST<br>RUTH  |  | MIDDLE  |  | LAST<br>ROGERS   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>2 7 82   |  | 2b. HOUR<br>12 <sup>15</sup> AM                 |  |
| 3. SEX<br>F   |  | 4. RACE<br>B   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>11 - 24 - 29  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>52 YRS.   |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS   |  | 8. IF UNDER 24 HRS<br>HOURS MIN.                |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>BALTIMORE  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.                           |  |   |  |   |  |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>BALTIMORE CITY HOSPITAL |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>HOUSEWIFE        |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |   |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13b. STATE<br>BALTIMORE   |  | 13c. CITY OR TOWN<br>BALTIMORE   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 13e. STREET ADDRESS<br>5115 WOLVERTON AVE.   |  |   |  |   |  |
| 14. FATHER'S NAME<br>14a. FIRST<br>14b. MIDDLE<br>14c. LAST<br>JOHN W. CHASE  |  | 15. MOTHER'S MAIDEN NAME<br>15a. FIRST<br>15b. MIDDLE<br>15c. LAST<br>MARtha SCOTT   |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>NO  |  | 16b. SOCIAL SECURITY NO.<br>214-263448   |  | 17. INFORMANT<br>ADDRESS<br>John W. Rogers 5115 Wolverton AVE.  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) 5789<br>DUE TO, OR AS A CONSEQUENCE OF (b) GI bleeding and<br>DUE TO, OR AS A CONSEQUENCE OF (c) Chronic renal failure  |  |  |  |   |  |  |  |   |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |  |  |   |  |  |  |   |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET<br>CITY OR TOWN<br>COUNTY<br>STATE  |  |  |  |   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost<br>saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |  |  |  |   |  |  |  |   |  |   |  |
| 22b. SIGNATURE<br>Lucien Levy   |  |  |  | DEGREE  |  |  |  | 22c. DATE SIGNED<br>2/7/82  |  |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>LUCIEN LEVY  |  |  |  | 22e. ADDRESS<br>BALT. CITY HOSP   |  |  |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial  |  | 23b. DATE<br>2-13-82   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>BALTIMORE CEMETARY  |  | 23d. LOCATION<br>CITY OR TOWN<br>BALTIMORE   |  | COUNTY<br>MARYLAND  |  | STATE   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>William J. Spicer   |  |  |  | ADDRESS<br>1639 N. Broadway   |  | 25a. DATE REC'D. BY REGISTRAR<br>FEB 9 1982  |  | 25b. REGISTRAR'S SIGNATURE<br>James J. Smith  |  |   |  |

PERMANENT

EXAMINATION

TO BE TAKEN IN THE CITY OF

NEW YORK

IN THE

OFFICE OF THE

COMMISSIONER OF

THE

DEPARTMENT OF

EDUCATION

IN THE

YEAR

1900

AND

1901

IN THE

MONTH OF

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 4 1 5 0

1- FOR  
STATE  
REGISTRAR

REG. NO.

|   |   |  |  |  |  |
|---|---|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>CHARLES M. ROEBUCK SR.</b>  |   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>2 21 82</b>  |  | 2b. HOUR<br><b>7P</b> M  |
| 3. SEX<br><b>Male</b>   | 4. RACE<br><b>White</b>   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Oct. 29, 1903</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>81</b> YRS   | 7. IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.   |
| 8. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   | 9. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   | 10. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 11. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.                                 |  |
| 12. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>   | 13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>UNION MEMORIAL HOSPITAL</b> |  |  | 14a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Executive</b>               | 14b. KIND OF BUSINESS OR INDUSTRY<br><b>Printing</b>   |
| 15a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>15a. STATE<br><b>Maryland</b>   | 15b. COUNTY<br><b>Baltimore</b>   | 15c. CITY OR TOWN<br><b>Baltimore</b>  | 15d. INSIDE CITY LIMITS?<br><b>YES</b> <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 15e. STREET ADDRESS<br><b>3700 N. Charles St.</b>  |  |
| 16. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Harry G. Roebuck</b>   |   |  | 17. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Henrietta Doubledee</b>                            |  |  |
| 18a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>   |   | 18b. SOCIAL SECURITY NO.<br><b>213 05 6782</b>   |  | 19. INFORMANT ADDRESS<br><b>Charles M. Roebuck, Jr. Balto., Md.</b>                                |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiac arrest</b><br><b>2898</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Myeloid Metaplasia</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |   |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |   |  |  |  |  |
| 19a. DATE OF OPERATION  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br><b>YES</b> <input type="checkbox"/> <b>NO</b> <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br><b>YES</b> <input type="checkbox"/> <b>NO</b> <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                         |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK<br>NOT WHILE <input type="checkbox"/> AT WORK  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |
| 22a. I certify that (this hospital) attended the deceased from <b>2/17</b> , 19 <b>82</b> , to <b>2/21</b> , 19 <b>82</b> , that (we) lost<br>saw the deceased alive on <b>2/21</b> , 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.                          |   |  |  |  |  |
| 22b. SIGNATURE<br><b>Brian H. Kahn</b>  |   | DEGREE<br><b>M.D.</b>  |  | 22c. DATE SIGNED<br><b>2/21/82</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>BRIAN H. KAHN</b>   |   | 22e. ADDRESS<br><b>UNION MEMORIAL HOSPITAL</b>   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   | 23b. DATE<br><b>2/24/82</b>   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Parkwood</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Balto. Co., Md.</b>                               |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Henry W. Jenkins &amp; Sons Co.</b><br>ADDRESS<br><b>4905 York Road Balto., Md. 21212</b>  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>FEB 24 1982</b>  |  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 10 days of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified by the funeral director.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  |   |  |  |  |  |  |
|---|--|--|--|---|--|--|--|--|--|
| 1. FOR STATE REGISTRAR  |  |  |  |   |  |  |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br>MARY C. ROSASCO  |  |  |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>2 - 10 - 82                                      |  | 2b. HOUR<br>8:22 AM  |  |
| 3. SEX<br>FEMALE  |  | 4. RACE<br>CAUCASIAN   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>08 31 1899  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>82  |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MARYLAND   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTO. CITY MD.                              |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>UNION MEMORIAL : HOSPITAL |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK OR MOST OF WORKING LIFE)<br>HOMEMAKER         |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>-----   |  |
| 13a. STATE<br>MARYLAND  |  |  |  |   |  | 13b. COUNTY<br>BALTIMORE   |  | 13c. CITY OR TOWN<br>BALTIMORE   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>BENDER (BENDA)  |  |  |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>STEPHEN ROSASCO                     |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) NO   |  |  |  |   |  | 16b. SOCIAL SECURITY NO.<br>218073257  |  | 17. INFORMANT ADDRESS<br>STEPHEN ROSASCO 2419 RECKORD RD.  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>GRAM NEGATIVE SEPTIC SHOCK</u><br>5990<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>URINARY TRACT GRAM NEGATIVE INFECTION</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(c) _____<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a)<br><u>GENERALIZED CHRONIC DEBILITATION</u> |  |  |  |   |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>FEB 8</u> , 19 <u>82</u> , to <u>FEB 10</u> , 19 <u>82</u> , that (I) (we) lost saw the deceased alive on <u>FEB 9</u> , 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.  |  |  |  |   |  |  |  |  |  |
| 22b. SIGNATURE<br>Charles W. Hicks, III MD  |  |  |  |   |  | DEGREE<br>M.D.   |  | 22c. DATE SIGNED<br>2-10-82  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Charles W. Hicks, III MD   |  |  |  |   |  | 22e. ADDRESS<br>201 E. UNIVERSITY PKWY.  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>BURIAL  |  | 23b. DATE<br>2/12/82   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>PARKWOOD CEMETERY   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>BALTO. BALTO. MD.                      |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Jody Ward 1211 Chesaco Ave.   |  |  |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br>FEB 11 1982   |  | 25b. REGISTRAR'S SIGNATURE<br>Thane Jan. [Signature]   |  |



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CHARTER

MEMORANDUM

TO : DIRECTOR, FBI

FROM : SAC, NEW YORK

SUBJECT :

(RE: )

RE: [Illegible text]

ON

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be retained by the funeral director. Page 3 should be retained by the funeral director. Page 4 should be retained by the funeral director. Page 5 should be retained by the funeral director. Page 6 should be retained by the funeral director. Page 7 should be retained by the funeral director. Page 8 should be retained by the funeral director. Page 9 should be retained by the funeral director. Page 10 should be retained by the funeral director. Page 11 should be retained by the funeral director. Page 12 should be retained by the funeral director. Page 13 should be retained by the funeral director. Page 14 should be retained by the funeral director. Page 15 should be retained by the funeral director. 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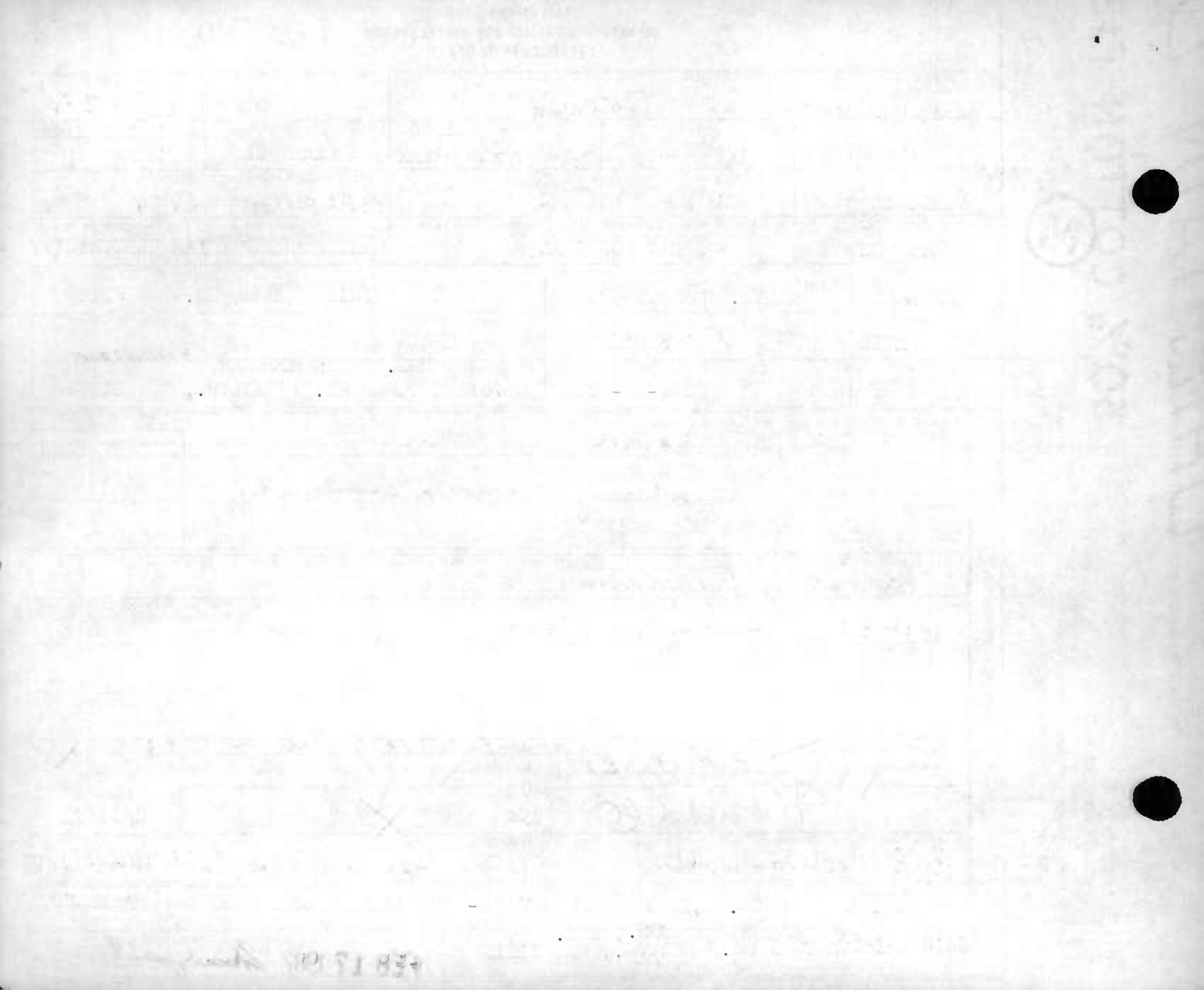
1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 4 1 5 2

REG. NO.

|  |  |  |  |   |  |   |  |  |  |
|--|--|--|--|---|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Robert S. Roseman</b>   |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>02-14-82</b> |   |  | 2b. HOUR<br>(Non)<br><b>12-P M</b>  |  |  |  |
| 3. SEX<br><b>MALE</b>  |  | 4. RACE<br><b>WHITE</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>09-02-1900</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>81</b> YRS  |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>VIRGINIA</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>       |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.                               |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>SINAI HOSPITAL</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>MASTER ELECTRICIAN</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>ELECTRICITY</b>  |  |
| 13a. STATE<br><b>MARYLAND</b>  |  | 13b. COUNTY<br><b>BALTO.</b>   |  | 13c. CITY OR TOWN<br><b>BALTIMORE</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>7011 CONCORD RD. #21208</b>  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>DAVID ROSEMAN</b>   |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>CELIA UNKNOWN</b>   |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>216-09-8325</b>  |  | 17. INFORMANT<br><b>MRS. SARAH ROSEMAN</b><br><b>7011 CONCORD RD. BALTO., MD 21208</b>  |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Septis</b><br><b>1569</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:<br>(b) <b>bilary carcinoma &amp; cholangitis</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Aspiration Pneumonia.</b> |  |  |  |   |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |  |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION<br><b>1-11-82</b>   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>Biliary Stasis &amp; Septis.</b>  |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |  |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>March 19 78</b> to <b>Feb. 14, 19 82</b> , that (I) (we) lost above, (I) (we) (did) (did not) view the body after death.   |  |  |  |   |  |   |  |  |  |
| 22b. SIGNATURE<br><b>B. A. Cochran, M.D.</b>   |  |  |  | DEGREE<br><b>MD</b><br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  |   |  | 22c. DATE SIGNED<br><b>2/14/82</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>B. A. Cochran, M.D.</b>  |  |  |  | 22e. ADDRESS<br><b>6506 PARK HEIGHTS AVE, BALTO MD 21215</b>  |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>BURIAL</b>   |  | 23b. DATE<br><b>FEB. 15, 1982</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>MIKRO KODESH-BETH ISRAEL</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>BALTIMORE MARYLAND</b>                         |  | 23e. DATE REC'D. BY REGISTRAR  |  |
| 24. FUNERAL DIRECTOR<br><b>SOL LEVINSON &amp; SONS, INC.</b><br><b>6010 REISTERSTOWN RD. BALTO., MD 21215</b>  |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>FEB 17 1982</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>James J. Hester</b>  |  |  |  |







TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of police.

DHMH - 16-50M 1/81  
(VRA 15, 4)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 4 1 5 3

|   |  |   |  |
|---|--|---|--|
| 1. FOR STATE REGISTRAR  |  | REG. NO.  |  |
| 1. DECEASED NAME (TYPE OR PRINT) <b>IRENE</b>   |  | 2a. DATE OF DEATH MONTH <b>2</b> DAY <b>15</b> YEAR <b>82</b>   |  |
| 3. SEX <b>FEMALE</b>  |  | 7b. HOUR <b>4:50 AM</b>   |  |
| 4. RACE <b>CAUC</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY) <b>68</b> YRS   |  |
| 5. DATE OF BIRTH MONTH <b>02</b> DAY <b>28</b> YEAR <b>13</b>   |  | IF UNDER 1 YEAR MONTHS <b>0</b> DAYS <b>0</b>   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>XXXXX MARYLAND</b>   |  | IF UNDER 24 HRS. HOURS <b>0</b> MIN. <b>0</b>   |  |
| 7b. CITIZEN OF WHAT COUNTRY? <b>US</b>  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b> MD.  |  |
| 10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>SINAI HOSPITAL OF BALTIMORE</b>   |  |
| 12a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>MARYLAND</b> 13b. COUNTY <b>BALTIMORE</b> 13c. CITY OR TOWN <b>BALTIMORE</b> 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 12b. USUAL WORK (TYPE OF WORK TO WHICH WORKING LIFE) <b>XXXXX SANDWICH MAKER</b> 12c. KIND OF BUSINESS OR INDUSTRY <b>FOOD</b>  |  |
| 14. FATHER'S NAME FIRST <b>MORRIS</b> MIDDLE <b>ROSENFELD</b> LAST <b>ROSENFELD</b>   |  | 15. MOTHER'S MAIDEN NAME FIRST <b>MARY</b> MIDDLE <b>FLEISCHMAN</b> LAST <b>FLEISCHMAN</b>  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b> (IF YES, GIVE WAR OR DATES)   |  | 16b. SOCIAL SECURITY NO. <b>214-14-4571</b>   |  |
| 17. INFORMANT <b>MR. EARL ROSENFELD</b>   |  | 18. ADDRESS <b>6807 PARK HTS. AVE., APT. 2F #21215</b>  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiogenic shock</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>acute infarction wall MI</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>ASCVD</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last <b>4100</b> |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a) <b>sepsis &amp; lactic acidosis, acute renal failure</b>   |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 20b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>  |  |
| 21a. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  | 21b. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>2-14-</b> 19 <b>82</b> , to <b>2-15</b> 19 <b>82</b> , that (1) (we) last saw the deceased alive on <b>2-15</b> 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (we) (did not) view the body after death.   |  | 22b. SIGNATURE <b>Michael McIvor MD</b> DEGREE <b>MD</b> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  |
| 22c. DATE SIGNED <b>2-15-82</b>   |  | 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>MICHAEL McIVOR MD</b>  |  |
| 22e. ADDRESS <b>SINAI HOSPITAL OF BALTIMORE, INC.</b>   |  | 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>   |  |
| 23b. DATE <b>FEB. 16, 1982</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY <b>SWINICHER WOLINER BENEVOLENT ASSOC. BALTO.</b>  |  |
| 23d. LOCATION CITY OR TOWN <b>BALTO.</b> COUNTY <b>BALTO.</b> STATE <b>MD</b>   |  | 24. FUNERAL DIRECTOR NAME <b>SOL LEVINSON &amp; BROS., INC.</b>   |  |
| 25a. DATE REC'D. BY REGISTRAR <b>FEB 17 1982</b>  |  | 25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>   |  |
| 26. ADDRESS <b>6010 REISTERSTOWN RD. BALTO., MD 21215</b>   |  |   |  |

MEDICAL CERTIFICATION

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FEB 1 1917

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITH COPIES, AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |  |  |  |   |  |   |  |   |  | REG. NO. 2 0 4 1 5 4                         |  |
|--|--|--|--|---|--|---|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Joseph Rosinski</b>   |  |  |  |   |  | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH <b>2</b> DAY <b>24</b> YEAR <b>1982</b> |  | 2b. HOUR <b>M</b>   |  |  |  |
| 3. SEX <b>Male</b>   |  | 4. RACE <b>White</b>   |  | 5. DATE OF BIRTH<br>MONTH <b>Dec</b> DAY <b>8</b> YEAR <b>1928</b>  |  | 6. AGE (IN YEARS)<br>LAST BIRTHDAY <b>53</b> YRS.   |  | 7c. DATE PRONOUNCED DEAD<br>MONTH <b>2</b> DAY <b>24</b> YEAR <b>1982</b>                                 |  | 2d. HOUR <b>5:50</b><br><b>A.</b> <b>M.</b>  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Md</b>  |  | 7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City, MD.</b>   |  |   |  |  |  |
| 10. CITY OR TOWN OF DEATH <b>Baltimore</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>J.L. Deaton Nursing Center</b> |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Guard</b>                                |  | 12b. KIND OF BUSINESS OR INDUSTRY <b>Security</b>   |  |  |  |
| 13a. STATE <b>Md</b>   |  | 13b. COUNTY  |  | 13c. CITY OR TOWN <b>Baltimore</b>  |  | 13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO              |  | 13e. STREET ADDRESS <b>713 S. Bond St.</b>  |  |  |  |
| 14. FATHER'S NAME<br>FIRST <b>Joseph</b> MIDDLE <b>Rosinski</b> LAST <b>Rosinski</b>   |  |  |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>Mary</b> MIDDLE <b>Kaczynski</b> LAST <b>Kaczynski</b>               |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, GIVE REG. NO. UNKNOWN) <b>No</b>   |  | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT <b>Nicholas Radzowski</b> ADDRESS <b>1801 Old Sound Rd</b>  |  |   |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Complication of Subdural Hematoma</b><br><b>8880</b><br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____   |  |  |  |   |  |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |  |  |   |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  |   |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                       |  |  |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>? P.M. 12 17 1981</b>   |  |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)<br><b>subject fell</b>      |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>   |  |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)<br><b>street</b>  |  |   |  | 21f. LOCATION<br>STREET <b>713 S. Bond St.</b> CITY OR TOWN <b>Baltimore</b> COUNTY <b>Maryland</b> STATE |  |  |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . |  |  |  |   |  |   |  |   |  |  |  |
| ACTUAL SIGNATURE <b>Virginia L. Dolan</b>  |  |  |  | TITLE (SPECIFY) <b>Assistant</b> M.D. MEDICAL EXAMINER  |  |   |  | DATE SIGNED <b>2-24-82</b>  |  |  |  |
| EXAMINER'S NAME (TYPE OR PRINT) <b>Virginia L. Dolan, M.D.</b>   |  |  |  | ADDRESS <b>111 Penn Street</b>  |  |   |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL <b>Burial</b>  |  |  |  | 23b. DATE <b>2-27-82</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY <b>Holy Rosary Cem</b>   |  | 23d. LOCATION<br>CITY OR TOWN <b>Baltimore</b> COUNTY <b>Md</b> STATE                                     |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME <b>Raymond L. Kaczowski</b> ADDRESS <b>5525 Heet St.</b>  |  |  |  | 25a. DATE REC'D. BY REGISTRAR <b>FEB 25 1982</b> 25b. REGISTRAR SIGNATURE <b>Frances J. [Signature]</b>   |  |   |  |   |  |  |  |

20X COPIES  
4-11-41  
DND



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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| FOR<br>1. STATE<br>REGISTRAR  |  |  |  | STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  | REG. NO.<br>73 80 26-12781 8 2 0 4 1 5 5                                  |                                   |  |  |
|---|--|--|--|---|--|--|--|---|-----------------------------------|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br><b>(NAYISHA) Diane Ross</b>  |  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>02 07 82</b>   |  |  |  | 2b. HOUR<br><b>12 NOON</b>  |                                   |  |  |
| 3. SEX<br><b>female</b>   |  | 4. RACE<br><b>Black</b>  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>11 11 81</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>YRS. <b>88</b>                              |  | IF UNDER 1 YEAR MONTHS DAYS<br><b>88</b>                                  |                                   | IF UNDER 24 HRS. HOURS MIN.<br><b>88</b>   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MARYLAND</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>City</b> MD.                        |  |   |                                   |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Balt</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Univ Maryland Hosp</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)               |  |   | 12b. KIND OF BUSINESS OR INDUSTRY |  |  |
| 13a. STATE<br><b>MD</b>   |  | 13b. COUNTY<br><b>Baltimore</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 13e. STREET ADDRESS<br><b>212 N. Mount St.</b>                                 |  |   |                                   |  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>Nathaniel Ross</b>  |  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Beverly English</b>  |  |  |  |   |                                   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>No</b>   |  |  |  | 16b. SOCIAL SECURITY NO.<br><b>N/A</b>  |  | 17. INFORMANT ADDRESS<br><b>Beverly English 212 N. Mount St.</b>               |  |   |                                   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CAADICORSP Arrest</b><br><b>3209</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>sepsis meningitis</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |  |  |   |  |  |  |   |                                   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)<br><b>Hydrocephalus</b>  |  |  |  |   |  |  |  |   |                                   |  |  |
| 19a. DATE OF OPERATION  |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                                   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |   |                                   |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |   |                                   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>1/10</b> , 19 <b>82</b> , to _____, 19 _____, that (I) (we) last saw the deceased alive on <b>2/17</b> , 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                      |  |  |  |   |  |  |  |   |                                   |  |  |
| 22b. SIGNATURE<br><b>W. March</b>   |  |  |  | DEGREE<br><b>MD</b>   |  |  |  | 22c. DATE SIGNED<br><b>2/17/82</b>  |                                   |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>MARCH W</b>   |  |  |  | 22e. ADDRESS<br><b>22 S. Greene St Balt MD</b>  |  |  |  |   |                                   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |  |  |  | 23b. DATE<br><b>2/11/82</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Mt. Auburn Cem.</b>                   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore MD</b>         |                                   |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Wm. C. March F/H</b>   |  |  |  |   |  | ADDRESS<br><b>1101 E. North Ave.</b>   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>FEB 9 1982</b>                        |                                   |  |  |
|   |  |  |  |   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Francis J. [Signature]</b>                    |  |   |                                   |  |  |

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LCB 8 1985  
J. J. J.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers, Pages 1 and 2, and 3 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at 1-800-368-1234.

DHMH - 16.50M 1/81  
(VRA 15, 4)

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  | REG. NO. 8 2 0 4 1 5 6  |  |   |  |
|---|--|--|--|---|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br><b>Beulah E. Rowe</b>   |  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>2 27 82</b>  |  |   |  |
| 3. SEX<br><b>FEMALE</b>   |  |  |  | 2b. HOUR<br><b>10:31 PM</b>   |  |   |  |
| 4. RACE<br><b>WHITE</b>   |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>2 27 09</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>72</b> YRS.   |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Balto.</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>St Agnes Hospital</b>                           |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.   |  |   |  |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Restaurant owner</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Self-Emp.</b>  |  |   |  |   |  |
| 13a. STATE<br><b>Md.</b>  |  | 13b. COUNTY<br><b>A.A.CO.</b>  |  | 13c. CITY OR TOWN<br><b>Hanover</b>   |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                            |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>David Souders</b>   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Ellen Koon</b>  |  | 13e. STREET ADDRESS<br><b>7178 Ridge Road</b>   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>NO</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>214-09-9457</b>   |  | 17. INFORMANT ADDRESS<br><b>Wilbur S. Rowe 7178 Ridge Road 21076</b>  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARDIAC ARREST</b><br><b>4275</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:<br>(b) _____<br>(c) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>DUE TO, OR AS A CONSEQUENCE OF |  |  |  |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____  |  |  |  |   |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2)  |  |   |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>July 1980</b> to <b>present</b> 19____, that (I) (we) last saw the deceased alive on <b>Jan 28</b> 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                      |  |  |  |   |  |   |  |
| 22b. SIGNATURE<br><b>[Signature]</b>  |  | DEGREE <b>MD.</b> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  |   |  | 22c. DATE SIGNED<br><b>2-22-82</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>R. HANIF MD.</b>  |  | 22e. ADDRESS<br><b>5808 MAIN ST, ELKridge MD 21227</b>   |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>2/25/82</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Crestlawn Cemetery</b>   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>Marriottsville Howard Md.</b>   |  |
| 24. FUNERAL DIRECTOR NAME<br><b>Hubbard Funeral Home, Inc.</b>  |  | ADDRESS<br><b>4107 Wilkens Ave.</b>  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>FEB 23 1982</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>  |  |

MEDICAL CERTIFICATION

WORLD



*[Faint, mostly illegible text and markings, possibly bleed-through from the reverse side of the page.]*

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |                         |   |  |   |  |   |  |   |  | REG. NO. 2 0 4 1 5 7 |  |
|--|-------------------------|---|--|---|--|---|--|---|--|----------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Frank Royal</b>   |                         |   |  |   |  | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> ESTIMATED <input type="checkbox"/> <b>2 20 1982</b> |  | 2b. HOUR <b>M</b>   |  |                      |  |
| 3. SEX<br><b>Male</b>  | 4. RACE<br><b>Black</b> | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>3 13 40</b>  | 6. AGE (IN YEARS)<br>LAST BIRTHDAY YRS.<br><b>41</b> | IF UNDER 1 YR.<br>MONTHS DAYS<br><b>0 0</b>   | IF UNDER 24 HRS.<br>HOURS MIN.<br><b>0 0</b> | 2c. DATE PRONOUNCED DEAD<br>MONTH DAY YEAR<br><b>2 20 1982</b>  |  | 2d. HOUR<br><b>7:26 P. M.</b>   |  |                      |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   |                         | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City, MD.</b>  |  |   |  |                      |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |                         | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Hanover St. north of Potee St.</b> |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Electrician</b>                             |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Unavailable</b>                             |  |                      |  |
| 13a. STATE<br><b>Maryland</b>  |                         | 13b. COUNTY<br><b>Baltimore</b>   |  | 13c. CITY OR TOWN<br><b>Baltimore</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                 |  | 13e. STREET ADDRESS<br><b>3001 Apt H Cherry Lane Rd. 21226</b>                      |  |                      |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Frank Royal, Sr.</b>  |                         |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Geneva Turner</b>   |  |   |  |   |  |                      |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br><b>NO</b>   |                         | 16b. SOCIAL SECURITY NO.<br><b>232-62-6237</b>  |  | 17. INFORMANT ADDRESS<br><b>W. Va. 26836<br/>Chambers Funeral Home 217 Winchester Ave.</b>  |  |   |  |   |  |                      |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Blunt injury to Head</b><br><b>8120</b><br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>DUE TO, OR AS A CONSEQUENCE OF  |                         |   |  |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |                      |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:  |                         |   |  |   |  |   |  |   |  |                      |  |
| 19a. DATE OF OPERATION   |                         |   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  |   |  | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |                      |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |                         | 21b. TIME OF INJURY<br>HOUR <input checked="" type="checkbox"/> MONTH DAY YEAR<br><b>7:15 P.M. 2 20 1982</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)<br><b>driver in auto/auto collision</b>                                       |  |   |  |   |  |                      |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>   |                         | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)<br><b>street</b>  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br><b>Hanover St. north of Potee St., Balto., Md.</b>   |  |   |  |   |  |                      |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |                         |   |  |   |  |   |  |   |  |                      |  |
| ACTUAL SIGNATURE <b>Virginia L. Dolan</b>  |                         |   |  | TITLE (SPECIFY)<br><b>M.D. Assistant</b>  |  | MEDICAL EXAMINER  |  | DATE SIGNED <b>2-21-82</b>  |  |                      |  |
| EXAMINER'S NAME (TYPE OR PRINT) <b>Virginia L. Dolan, M.D.</b>   |                         |   |  | ADDRESS <b>111 Penn Street</b>  |  |   |  |   |  |                      |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Removal/Burial</b>   |                         | 23b. DATE<br><b>2/23/82</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Oak Hill Cemetery</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Moorefield Hardy W. Virginia</b>                               |  |   |  |                      |  |
| 24. FUNERAL DIRECTOR<br>NAME <b>Hubbard Funeral Home, Inc. Balto., Md.</b>   |                         |   |  | 25. DATE REC'D. BY REGISTRAR<br><b>FEB 24 1982</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Thomas J. [Signature]</b>  |  |   |  |                      |  |
| Chambers Funeral Home 217 Winchester Ave. 26836  |                         |   |  |   |  |   |  |   |  |                      |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified by page 3.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  | 8 2 0 4 1 5 8   |  |  |  |
|---|--|---|--|---|--|--|--|
| 1. FOR STATE REGISTRAR  |  |   |  | REG. NO.  |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Joyce Marie Russell</b>  |  |   |  | 2a. DATE OF DEATH<br>MONTH <b>2</b> / DAY <b>12</b> / YEAR <b>82</b>  |  |  |  |
| 3. SEX<br><b>Female</b>   |  | 4. RACE<br><b>Black</b>   |  | 5. DATE OF BIRTH<br>MONTH <b>12</b> / DAY <b>18</b> / YEAR <b>52</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>29</b> YRS.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>md.</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>               |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore city</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>University of Maryland Hospital</b> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Shipping clerk</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13a. STATE<br><b>Maryland</b>   |  | 13b. COUNTY<br><b>A.A.</b>  |  | 13c. CITY OR TOWN<br><b>Baltimore</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  |
| 14. FATHER'S NAME<br>FIRST <b>James</b> MIDDLE <b>Lee</b> LAST <b>Russell</b>   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>Margaret</b> MIDDLE <b>V.</b> LAST <b>Hankins</b>  |  | 16. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>No</b>   |  |  |  |
| 16a. SOCIAL SECURITY NO.<br><b>216-60 5264</b>  |  | 17. INFORMANT ADDRESS<br><b>Margaret V. Russell 236 Bishop Ave.</b>   |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I: DEATH WAS CAUSED BY<br><b>6426</b> IMMEDIATE CAUSE (a) <b>Cardiovascular collapse</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Massive intracerebral bleed</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Eclampsia</b>  |  |   |  |   |  |  |  |
| PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)<br><b>PREGNANCY</b>  |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION<br><b>—</b>  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>—</b>  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>2/11/82</b> , 19 <b>82</b> , to <b>2/12/82</b> , 19 <b>82</b> , that (I) (we) lost saw the deceased alive on <b>3:15 AM 2/12/82</b> , 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |  |   |  |  |  |
| 22b. SIGNATURE<br><b>Philip R. Bowman MD.</b>   |  |   |  | DEGREE<br><b>ATTENDING PHYSICIAN</b> <input checked="" type="checkbox"/> <b>MEDICAL DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYSICIAN</b> <input type="checkbox"/> |  | 22c. DATE SIGNED<br><b>2/12/82</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Philip R. Bowman</b>  |  |   |  | 22e. ADDRESS  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>2/16/82</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Cedar Hill Cem.</b>  |  | 23d. LOCATION<br>CITY OR TOWN <b>Baltimore</b> COUNTY <b>Co.</b> STATE <b>MD</b>   |  |
| 24. FUNERAL DIRECTOR<br>NAME <b>Wm. C. March F/H</b> ADDRESS <b>1101 E. North Ave.</b>  |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>FEB 16 1982</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Thomas J. North</b>   |  |

BP



RECEIVED  
JAN 1 1965

Mr. H. J. ...

RECEIVED  
JAN 1 1965  
FBI - NEW YORK

NO



**TO MEDICAL EXAMINER:** THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE  
**TO FUNERAL DIRECTOR:** PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED  
**TO FURNAL DIRECTOR:** PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED  
 AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W.  
 BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP \_\_\_\_\_  
DHMH-17  
(VR A15 ME (5))  
15M 2/80

Shipped to: **Raiano Mdaobw**

Shipped to: **Balano Meadowbrook Funeral Home** | **Hamden, Conn** 06514

## REG. NO.

|  |         |   |                   |  |                        |
|--|---------|---|-------------------|--|------------------------|
| 1- STATE REGISTRAR   |         | FOR DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |                   | 2 0 4 1 5 9  |                        |
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |         |   |                   |  |                        |
| 1. DECEASED NAME (TYPE OR PRINT)   |         | 2b. DATE KNOWN OF DEATH   |                   | 2c. DATE PRONOUNCED DEAD   |                        |
| Assunta (Sue) Russo  |         | 2b. DATE KNOWN OF DEATH ESTIMATED MONTH DAY YEAR 2 1 19 82  |                   | 2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 2 1 19 82                            |                        |
| 3. SEX   | 4. RACE | 5. DATE OF BIRTH  | 6. AGE (IN YEARS) | 7. IF UNDER 1 YR.  | 7. IF UNDER 24 HRS.    |
| Female   | White   | 8 15 1912   | 69 YRS.           | MONTHS DAYS HOURS MIN.   | MONTHS DAYS HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |         | 7b. CITIZEN OF WHAT COUNTRY?  |                   | 9. BALTIMORE CITY OR COUNTY OF DEATH   |                        |
| Bronx, N.Y.  |         | U.S.A.  |                   | Baltimore City, MD.  |                        |
| 10. CITY OR TOWN OF DEATH  |         | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |                   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                |                        |
| Baltimore  |         | 1010 St. Paul Street  |                   | retired-Supervisor   |                        |
| 13a. STATE   |         | 13b. CITY OR TOWN   |                   | 13c. STREET ADDRESS  |                        |
| Maryland   |         | Baltimore   |                   | 1010 St. Paul Street   |                        |
| 14. FATHER'S NAME  |         | 15. MOTHER'S MAIDEN NAME  |                   | 16. SOCIAL SECURITY NO.  |                        |
| Angelo Russo   |         | Carmela Santillo  |                   | 045-09-7040  |                        |
| 17. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)  |         | 18. INFORMANT   |                   | 19. ADDRESS  |                        |
| no   |         | Pat Russo   |                   | Hamden, Conn. 06514  |                        |
| 20. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |         | 21. IMMEDIATE CAUSE (a)   |                   | 22. DUE TO, OR AS A CONSEQUENCE OF   |                        |
| PART I DEATH WAS CAUSED BY:  |         | Arteriosclerotic cardiovascular disease   |                   |  |                        |
| 4292   |         | (b)   |                   | (c)  |                        |
| 23. PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) |         | 24. DATE OF OPERATION   |                   | 25. CONDITION FOR WHICH OPERATION WAS PERFORMED?                             |                        |
|  |         | 24. DATE OF OPERATION   |                   | 25. CONDITION FOR WHICH OPERATION WAS PERFORMED?                             |                        |
| 26. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH   |         | 27. TIME OF INJURY  |                   | 28. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |                        |
|  |         | 27. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19   |                   | 28. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |                        |
| 29. INJURY OCCURRED WHILE AT WORK OR NOT WHILE AT WORK   |         | 30. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)  |                   | 31. LOCATION   |                        |
|  |         | 30. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)  |                   | 31. LOCATION CITY OR TOWN COUNTY STATE                                       |                        |
| 32. I certify that I took charge of the remains described above, held on death resulted from:  |         | 33. Autopsy   |                   | 34. Inquiry  |                        |
| 32. I certify that I took charge of the remains described above, held on death resulted from:  |         | 33. Autopsy   |                   | 34. Inquiry  |                        |
| 35. ACTUAL SIGNATURE   |         | 36. TITLE (SPECIFY)   |                   | 37. DATE SIGNED  |                        |
| Thomas D. Smith, M.D.  |         | Deputy Chief  |                   | 2/2/82   |                        |
| 38. EXAMINER'S NAME (TYPE OR PRINT)  |         | 39. ADDRESS   |                   | 40. BALTIMORE CITY OR COUNTY OF DEATH  |                        |
| Thomas D. Smith, M.D.  |         | 111 Penn St. Balto., Md.  |                   | Baltimore City, MD.  |                        |
| 41. BURIAL, CREMATION, REMOVAL (SPECIFY)   |         | 42. DATE  |                   | 43. NAME OF CEMETERY OR CREMATORY  |                        |
| Cremation  |         | 2/6/82  |                   | Evergreen Crematory  |                        |
| 44. FUNERAL DIRECTOR   |         | 45. DATE REC'D. BY REGISTRAR  |                   | 46. REGISTRAR'S SIGNATURE  |                        |
| Zannino Funeral Home, 263 S. Conkling St   |         | FEB 5 1982  |                   | Francis J. Santhron  |                        |



FOX CATION FIBRE

NEW YORK DOWD

605-815-405, 605-815-406

1001 Lexington Avenue, New York 17, N.Y.

1001 Lexington Avenue, New York 17, N.Y.

1001 Lexington Avenue, New York 17, N.Y.

1001 Lexington Avenue, New York 17, N.Y.

1001 Lexington Avenue, New York 17, N.Y.

1001 Lexington Avenue, New York 17, N.Y.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove corollary pages. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a medical examination must be made.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |  |  | 8 2 0 4 1 6 0   |  |   |   |
|---|--|--|--|---|--|---|---|
| 1. FOR STATE REGISTRAR  |  |  |  | REG. NO.  |  |   |   |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>JUANITA M. RYAN</b>  |  |  |  | 2a. DATE OF DEATH<br>MONTH <b>02</b> DAY <b>22</b> YEAR <b>82</b>   |  | 2b. HOUR<br><b>3:17pm</b>   |   |
| 3. SEX<br><b>Female</b>   |  | 4. RACE<br><b>W</b>  |  | 5. DATE OF BIRTH<br>MONTH <b>11</b> DAY <b>17</b> YEAR <b>18</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>63</b> YRS  |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.   |   |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE CITY</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>St. Agnes Hospital</b> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Homemaker</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>HOME</b>  |   |
| 13a. STATE<br><b>MD</b>   |  |  |  | 13b. COUNTY<br><b>Carroll</b>   |  | 13c. CITY OR TOWN<br><b>Westminster</b>   |   |
| 14. FATHER'S NAME<br>FIRST <b>Horatio</b> MIDDLE <b>Mathias</b> LAST <b>Fannie</b>  |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>Fannie</b> MIDDLE <b>German</b> LAST <b>German</b>   |  |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>None</b>   |  | 17. INFORMANT<br>ADDRESS<br><b>DONALD H. RYAN WESTMINSTER, MD.</b>  |  |   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>MYOCARDIAL INFARCTION, ACUTE</b><br>4100<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>OCCLUSION, CORONARY ARTERY, RIGHT</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>ATHEROSCLEROSIS</b>   |  |  |  |   |  |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).  |  |  |  |   |  |   |   |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. <b>19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>02/21</b> , 19 <b>82</b> , to <b>02/22</b> , 19 <b>82</b> , that (I) (we) lost<br>saw the deceased alive on <b>02/22</b> , 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |  |  |  |   |  |   |   |
| 22b. SIGNATURE<br><i>Michael P. Pelayo</i>  |  |  |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                   |  | 22c. DATE SIGNED<br><b>2/23/82</b>  |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Michael P. Pelayo</b>   |  |  |  | 22e. ADDRESS  |  |   |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>2- 25- 82</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Leister, s</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>WESTMINSTER CARROLL MD.</b>  |   |
| 24. FUNERAL DIRECTOR<br>NAME <b>Robert Kyle Smith Jr.</b> <b>Westminster, Md.</b>   |  |  |  | 25. RECEIVED BY REGISTRAR<br><b>MAR 1 1982</b>  |  |   |   |

2:17pm

00123732

2700

10/11/70

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10/11/70

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove copies of pages 1 and 2 and file with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 4 1 6 1

REG. NO.

|  |  |   |  |   |  |
|--|--|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>PAULA J. SADLOWSKI</b>   |  |   | 2a. DATE OF DEATH<br>(Feb.) <b>Feb 9 1982</b><br>2b. HOUR<br><b>8:15 AM</b>                          |   |  |
| 3. SEX<br><b>Female</b>  | 4. RACE<br><b>Caucasian</b>  | 5. DATE OF BIRTH<br><b>May 10 1953</b>  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>28</b><br>YRS.   |   | IF UNDER 1 YEAR<br>MONTHS<br>DAYS<br>HOURS<br>MIN.   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Virginia</b>   | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD                                     |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>N/A</b>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>JOHNS HOPKINS HOSPITAL</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Supt. Correspondence-NADA</b> |   | 12b. KIND OF BUSINESS OR INDUSTRY  |
| 13a. STATE<br><b>Virginia</b>  |  |   | 13b. CITY OR TOWN<br><b>Falls Church</b>   | 13c. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | 13d. STREET ADDRESS<br><b>2807 Woodlawn Avenue</b>   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Stanley J. Sadlowski</b>  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE<br><b>Bianca C. Catalano</b>                                |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(S. NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>No</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>223-80-0221</b>  | 17. INFORMANT<br>ADDRESS<br><b>2807 Woodlawn Ave.<br/>Bianca C. Sadlowski/Falls Church, Va.</b>      |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a). <b>ANOREXIA</b><br><b>1991</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost<br>(b). <b>METASTATIC MEDULLARY THYROID CARCINOMA</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c).<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>DAYS</b><br><b>YEARS</b> |  |   |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>DYSPLASIA ESOPHAGEAL DYSMOTILITY</b>   |  |   |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>            | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)                  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>Jan 19 1982</b> to <b>Feb 9 1982</b> , that (I) (we) last saw the deceased alive on <b>February 9 1982</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |   |  |   |  |
| 22b. SIGNATURE<br><b>Joseph M. Arcadi, Jr. MD</b>  |  | DEGREE<br><b>MD</b>   |  | 22c. DATE SIGNED<br><b>2/9/82</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>JOSEPH M. ARCADY, JR.</b>  |  | 22e. ADDRESS<br><b>1620 MARYLAND AVE SE BALTIMORE MD 21205</b>  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(15) <b>Burial</b>  |  | 23b. DATE<br><b>2/13/82</b>   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Holy Cross Cemetery Brooklyn</b>                            |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>New York</b>  |
| 24. FUNERAL DIRECTOR<br><b>Murphy Funeral Homes-Falls Church, Va.</b>  |  |   | 25. PREPARED BY (TYPE OR PRINT) SIGNATURE<br><b>FEB 17 1982</b>                                      |   |  |

CHILD IN TRANSFER

CHILD IN TRANSFER

CHILD IN TRANSFER

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  | REG. NO. 8204162  |  |  |  |
|---|--|--|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Regina C Salmon</b>  |  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR <b>February 1, 1982</b>  |  |  |  |
| 3. SEX <b>Female</b>  |  | 4. RACE <b>White</b>   |  | 5. DATE OF BIRTH <b>August 23, 1910</b>   |  | 2b. HOUR <b>1:30 PM</b>  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Penna.</b>   |  | 7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY) <b>71</b>   |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.   |  |
| 10. CITY OR TOWN OF DEATH <b>Baltimore</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br><b>1122 Ramblewood Rd Apt B</b> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City MD.</b>   |  | 12a. USUAL OCCUPATION (TYPE OF WORK OR MOST OF WORKING LIFE) <b>Clerk</b>  |  |
| 13a. STATE <b>Maryland</b>  |  | 13b. COUNTY <b>Baltimore</b>   |  | 13c. STREET ADDRESS <b>1122 Ramblewood Rd</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY <b>D.M.V.</b>  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Daniel F McCarthy</b>  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Catherine Carry</b>                    |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>No</b> |  |  |  |
| 16b. SOCIAL SECURITY NO. <b>117-30-4980</b>   |  | 17. INFORMANT ADDRESS<br><b>Mr Charles Salmon Same</b>                                     |  |   |  | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Ventricular fibrillation</b><br><b>2500</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Probable myocardial ischemia</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Diabetes mellitus</b><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>12-1501455</b><br><b>30725</b> |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>None</b>  |  |  |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                          |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER).   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>                          |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)                                |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                     |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>11</b> , 19 <b>81</b> , to <b>1</b> , 19 <b>82</b> , that (I) (we) lost the deceased alive on <b>1-21</b> , 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) (did) (did not) view the body after death. |  |  |  |   |  |  |  |
| 22b. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>James H Mersey M.D.</b>   |  |  |  | 22c. DATE SIGNED<br><b>2/2/82</b>   |  | 22d. ADDRESS<br><b>6701 North Charles St Towson, Maryland</b>  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>2/6/82</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Calvary</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Pittsburgh, Penna.</b>  |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Leonard J Ruck Inc. Baltimore, Maryland</b>  |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>FEB 2 1982</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><i>Thomas J. ...</i>   |  |

同



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS ANTICIPATED, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 3 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

1- FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

|  |  |                  |                 |  |  |   |  |   |                 |                  |  |   |  |   |                       |   |  |  |  |
|--|--|------------------|-----------------|--|--|---|--|---|-----------------|------------------|--|---|--|---|-----------------------|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  |                  | FIRST<br>Calvin |  |  | MIDDLE<br>F.  |  |   | LAST<br>Sanders |                  |  | 2a. DATE KNOWN OF DEATH<br>MONTH DAY YEAR<br>2 3 19 82  |  |   | 2b. HOUR<br>M<br>3:50 |   |  |  |  |
| 3. SEX<br>Male   |  | 4. RACE<br>Black |                 | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>9 18 53  |  | 6. AGE (IN YEARS<br>LAST BIRTHDAY)<br>28 YRS.                 |  | IF UNDER 1 YR.<br>MONTHS DAYS HOURS MIN.  |                 | IF UNDER 24 HRS. |  | 7c. DATE PRONOUNCED DEAD<br>MONTH DAY YEAR<br>2 3 19 82   |  |   | 2d. HOUR<br>M<br>3:50 |   |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MD  |  |                  |                 | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  |   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                 |                  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City, MD.                                     |  |   |                       |   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore   |  |                  |                 | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Johns Hopkins Hospital |  |   |  |   |                 |                  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                                   |  |   |                       | 12b. KIND OF BUSINESS OR INDUSTRY           |  |  |  |
| 13a. STATE<br>MD   |  |                  |                 | 13b. COUNTY  |  |   |  | 13c. CITY OR TOWN<br>Baltimore  |                 |                  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |   |                       | 13e. STREET ADDRESS<br>1620 E. 31st St.     |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>John R. Sanders  |  |                  |                 |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Verlia Brice |  |   |                 |                  |  |   |  |   |                       |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br>No  |  |                  |                 | (IF YES, GIVE WAR OR DATES)  |  |   |  | 16b. SOCIAL SECURITY NO.<br>212-60-4356   |                 |                  |  | 17. INFORMANT<br>Verlia Sanders   |  |   |                       | ADDRESS<br>1620 E. 31st St.                 |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Multiple Stab Wounds</u><br><u>9660</u><br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost:<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>DUE TO, OR AS A CONSEQUENCE OF  |  |                  |                 |  |  |   |  |   |                 |                  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |                       |   |  |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).  |  |                  |                 |  |  |   |  |   |                 |                  |  |   |  |   |                       |   |  |  |  |
| 19a. DATE OF OPERATION   |  |                  |                 | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  |   |  |   |                 |                  |  |   |  | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                       |   |  |  |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |  |                  |                 | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>1:59xx 2 3 19 82  |  |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)<br>subject was stabbed  |                 |                  |  |   |  |   |                       |   |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>   |  |                  |                 | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)<br>basement  |  |   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br>1536 N. Bond St., Baltimore, Maryland  |                 |                  |  |   |  |   |                       |   |  |  |  |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> . |  |                  |                 |  |  |   |  |   |                 |                  |  |   |  |   |                       |   |  |  |  |
| ACTUAL SIGNATURE<br><u>Virginia L. Dolan</u>   |  |                  |                 | TITLE (SPECIFY)<br>Assistant   |  |   |  | M.D. MEDICAL EXAMINER   |                 |                  |  | DATE SIGNED<br>2-3-82   |  |   |                       |   |  |  |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)<br>Virginia L. Dolan, M.D.,   |  |                  |                 | ADDRESS<br>111 Penn Street   |  |   |  |   |                 |                  |  |   |  |   |                       |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial   |  |                  |                 | 23b. DATE<br>2/6/82  |  |   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Baltimore Cemetery  |                 |                  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Balto. MD   |  |   |                       |   |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Wm. C. March F/H, Inc.   |  |                  |                 |  |  |   |  |   |                 |                  |  | ADDRESS<br>1101 E. North Ave.   |  |   |                       | 25a. DATE REC'D. BY REGISTRAR<br>FEB 4 1987 |  | 25b. REGISTRAR'S SIGNATURE<br><u>Thomas J. [Signature]</u> |  |

20% COTTON FIBER

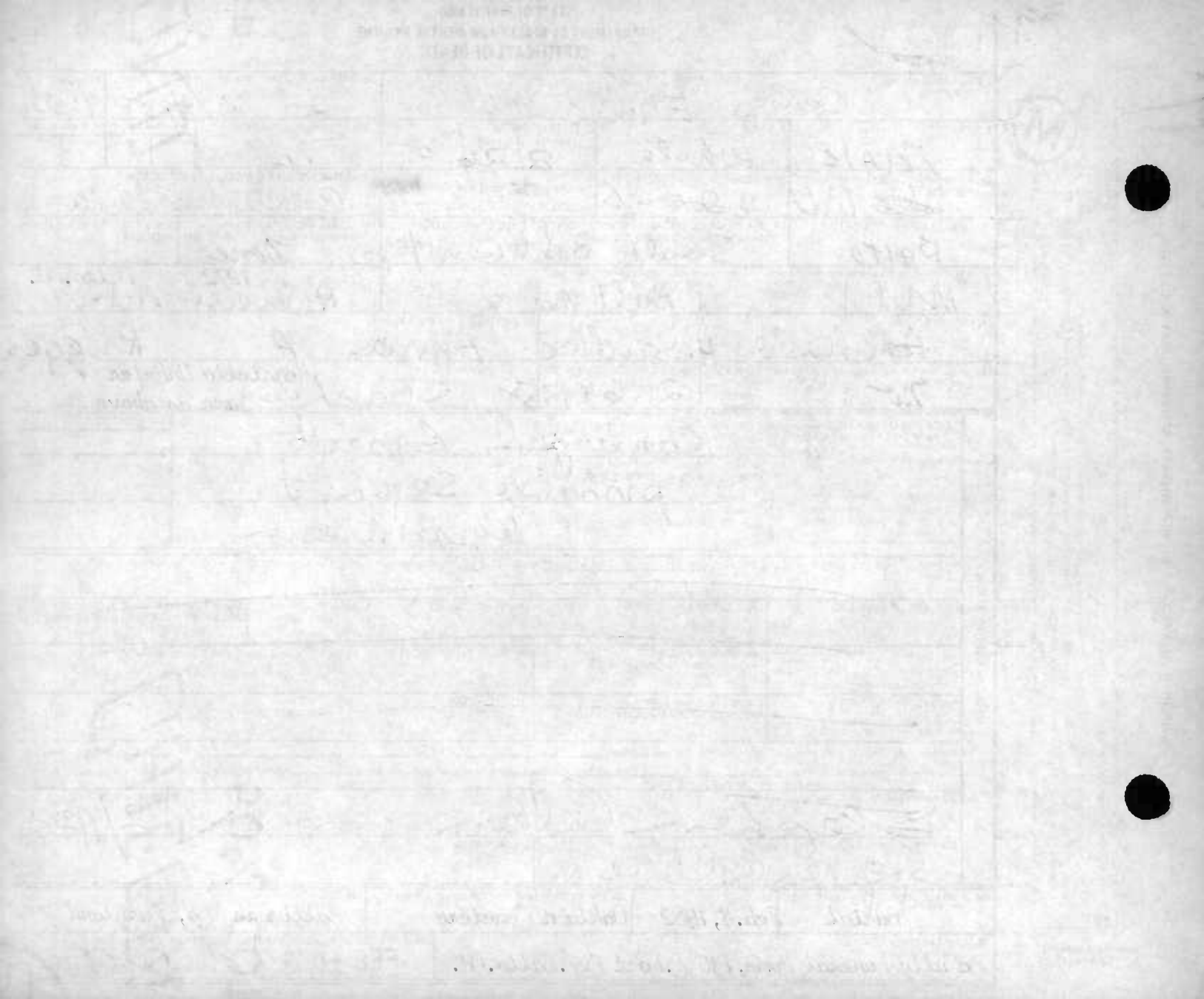
100% COTTON FIBER

100% COTTON FIBER

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of case.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |         |  |   |  |                                 |  |  |  | 8 2 0 4 1 6 4   |  |   |  |                                   |                                 |  |  |
|--|--|---------|--|---|--|---------------------------------|--|--|--|---|--|---|--|-----------------------------------|---------------------------------|--|--|
| 1. FOR STATE REGISTRAR   |  |         |  |   | REG. NO.   |                                 |  |  |  |   |  |   |  |                                   |                                 |  |  |
| 1. DECEASED NAME (TYPE OR PRINT)   |  |         |  |   | FIRST MIDDLE LAST  |                                 |  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR                              |  |   |  | 2b. HOUR MIN.                     |                                 |  |  |
| George Elmer Sandlass  |  |         |  |   |  |                                 |  |  |  | 2 2/4/82  |  |   |  | 9:50 AM                           |                                 |  |  |
| 3. SEX   |  | 4. RACE |  | 5. DATE OF BIRTH MONTH DAY YEAR                                     |  | 6. AGE (IN YEARS LAST BIRTHDAY) |  |  |  | 7. REMAINDER 1 YEAR MONTHS DAYS                               |  | IF UNDER 24 HRS. HOURS MIN.   |  |                                   |                                 |  |  |
| Male   |  | White   |  | 2/26/85   |  | 76                              |  |  |  | YES   |  |   |  |                                   |                                 |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  |         |  |   | 7b. CITIZEN OF WHAT COUNTRY?   |                                 |  |  |  | 8. BALTIMORE CITY OR COUNTY OF DEATH                          |  |   |  |                                   |                                 |  |  |
| US MD  |  |         |  |   | US MD  |                                 |  |  |  | Baltimore City MD.  |  |   |  |                                   |                                 |  |  |
| 10. CITY OR TOWN OF DEATH  |  |         |  |   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |                                 |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) |  |   |  | 12b. KIND OF BUSINESS OR INDUSTRY |                                 |  |  |
| Balto.   |  |         |  |   | South Balt Gen Hosp  |                                 |  |  |  | None  |  |   |  |                                   |                                 |  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE  |  |         |  |   | 13b. COUNTY  |                                 |  |  |  | 13c. INSIDE CITY LIMITS? YES NO                               |  |   |  |                                   | 13d. STREET ADDRESS             |  |  |
| Md   |  |         |  |   | Balt Md  |                                 |  |  |  | YES   |  |   |  |                                   | 1272 Balto. Md. Riverside Ave   |  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST  |  |         |  |   | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST   |                                 |  |  |  |   |  |   |  |                                   |                                 |  |  |
| Charles H. Sandlass  |  |         |  |   | Anna Krigger   |                                 |  |  |  |   |  |   |  |                                   |                                 |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)  |  |         |  |   | 16b. SOCIAL SECURITY NO.   |                                 |  |  |  | 17. INFORMANT ADDRESS   |  |   |  |                                   |                                 |  |  |
| NO   |  |         |  |   | 215641758  |                                 |  |  |  | S. Calher   |  |   |  |                                   | Henrietta Unkefer Same as above |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c)  |  |         |  |   |  |                                 |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                  |  |   |  |                                   |                                 |  |  |
| 0389 Cardiac Arrest  |  |         |  |   |  |                                 |  |  |  |   |  |   |  |                                   |                                 |  |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.   |  |         |  |   |  |                                 |  |  |  |   |  |   |  |                                   |                                 |  |  |
| probable sepsis + Hypotension.   |  |         |  |   |  |                                 |  |  |  |   |  |   |  |                                   |                                 |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |         |  |   |  |                                 |  |  |  |   |  |   |  |                                   |                                 |  |  |
|  |  |         |  |   |  |                                 |  |  |  |   |  |   |  |                                   |                                 |  |  |
| MEDICAL CERTIFICATION  |  |         |  |   |  |                                 |  |  |  |   |  |   |  |                                   |                                 |  |  |
| 19a. DATE OF OPERATION   |  |         |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                    |  |                                 |  | 20a. AUTOPSY? YES NO   |  |   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES NO |  |                                   |                                 |  |  |
|  |  |         |  |   |  |                                 |  |  |  |   |  |   |  |                                   |                                 |  |  |
| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |         |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19                |  |                                 |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |   |  |   |  |                                   |                                 |  |  |
|  |  |         |  |   |  |                                 |  |  |  |   |  |   |  |                                   |                                 |  |  |
| 21d. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK   |  |         |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  |                                 |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                 |  |   |  |   |  |                                   |                                 |  |  |
|  |  |         |  |   |  |                                 |  |  |  |   |  |   |  |                                   |                                 |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 19 to 19, that (I) (we) lost saw the deceased alive on 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |         |  |   |  |                                 |  |  |  |   |  |   |  |                                   |                                 |  |  |
| 22b. SIGNATURE DEGREE  |  |         |  |   |  |                                 |  |  |  | 22c. DATE SIGNED  |  |   |  |                                   |                                 |  |  |
| Stephen Calher   |  |         |  |   |  |                                 |  |  |  | 2/4/82  |  |   |  |                                   |                                 |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  |         |  |   |  |                                 |  |  |  | 22e. ADDRESS  |  |   |  |                                   |                                 |  |  |
| Stephen Calher   |  |         |  |   |  |                                 |  |  |  |   |  |   |  |                                   |                                 |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  |         |  | 23b. DATE   |  |                                 |  | 23c. NAME OF CEMETERY OR CREMATORY   |  |   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE                               |  |                                   |                                 |  |  |
| Burial   |  |         |  | Feb. 8, 1982  |  |                                 |  | Oaklawn Cemetery   |  |   |  | Baltimore Co, Maryland  |  |                                   |                                 |  |  |
| 24. FUNERAL DIRECTOR NAME ADDRESS  |  |         |  |   |  |                                 |  |  |  | 25a. DATE REC'D. BY REGISTRAR                                 |  |   |  | 25b. REGISTRAR'S SIGNATURE        |                                 |  |  |
| McMully Funeral Home, 130 E. Fort Ave. Balto. Md.  |  |         |  |   |  |                                 |  |  |  | FEB 10 1982   |  |   |  | Anne J. [Signature]               |                                 |  |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |  |  |  |  |  |  |  |  | 8 2 0 4 1 6 5   |  |                             |  |
|--|--|--|--|--|--|--|--|--|--|---|--|-----------------------------|--|
| 1. FOR STATE REGISTRAR   |  |  |  | CERTIFICATE OF DEATH   |  |  |  | REG. NO.   |  |   |  |                             |  |
| 1. DECEASED NAME (TYPE OR PRINT)   |  |  |  | FIRST MIDDLE LAST  |  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR   |  |   |  | 2b. HOUR                    |  |
| RALPH RALPH LOUIS L. SAPIA   |  |  |  |  |  |  |  | 2-26-82  |  |   |  | 5:40 PM                     |  |
| 3. SEX   |  | 4. RACE  |  | 5. DATE OF BIRTH MONTH DAY YEAR  |  |  |  | 6. AGE (IN YEARS LAST BIRTHDAY)  |  | IF UNDER 1 YEAR MONTHS DAYS   |  | IF UNDER 24 HRS. HOURS MIN. |  |
| MALE   |  | WHITE  |  | 02 22 18   |  |  |  | 64 YRS.  |  |   |  |                             |  |
| 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |  |  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH   |  |   |  |                             |  |
| MARYLAND   |  | U.S.A.   |  |  |  |  |  | BALTIMORE CITY   |  |   |  | MD.                         |  |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |  |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                  |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |                             |  |
| BALTIMORE  |  | ST. AGNES HOSPITAL   |  |  |  |  |  | OWNER  |  | HOTEL BUSINESS  |  |                             |  |
| 13a. STATE   |  |  |  | 13b. CITY OR TOWN  |  | 13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS  |  |   |  |                             |  |
| MARYLAND   |  | BALTIMORE  |  | ARBUTUS  |  |  |  | 5103 WESTLAND BOULEVARD, 21227   |  |   |  |                             |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST  |  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST   |  |  |  |  |  |   |  |                             |  |
| SALVADORE  |  |  |  | SAPIA  |  |  |  | GENEVIEVE  |  |   |  | FUSCO                       |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)  |  |  |  | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)   |  | 17. INFORMANT ADDRESS  |  |  |  |   |  |                             |  |
| YES  |  |  |  | WW II  |  | 212-12-4232 RALPH SAPIA, JR. 5103 WESTLAND BOULEVARD   |  |  |  |   |  |                             |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:  |  |  |  |  |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |                             |  |
| IMMEDIATE CAUSE (a) Advanced lung carcinoma  |  |  |  |  |  |  |  |  |  |   |  |                             |  |
| DUE TO, OR AS A CONSEQUENCE OF (b)   |  |  |  |  |  |  |  |  |  |   |  |                             |  |
| DUE TO, OR AS A CONSEQUENCE OF (c)   |  |  |  |  |  |  |  |  |  |   |  |                             |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |  |  |  |  |  |  |  |  |   |  |                             |  |
| 19a. DATE OF OPERATION   |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>         |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |                             |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19   |  |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) |  |   |  |                             |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  |  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                 |  |   |  |                             |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 2/26, 19 82, to 2/26, 19 82, that (I) (we) last saw the deceased alive on 2/26, 19 82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |  |  |  |  |   |  |                             |  |
| 22b. SIGNATURE   |  |  |  |  |  | DEGREE   |  | 22c. DATE SIGNED   |  |   |  |                             |  |
| W. Bradley Pifalo  |  |  |  |  |  |  |  | 2/26/82  |  |   |  |                             |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  |  |  |  |  | 22e. ADDRESS   |  |  |  |   |  |                             |  |
| W. BRADLEY PIFALO  |  |  |  |  |  | ST. AGNES HOSPITAL   |  |  |  |   |  |                             |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  |  |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE  |  |   |  |                             |  |
| BURIAL   |  |  |  | 03-02-82   |  | LOUDON PARK  |  | BALTIMORE CITY   |  |   |  | MARYLAND                    |  |
| 24. FUNERAL DIRECTOR NAME  |  |  |  |  |  | 24b. ADDRESS   |  | 25a. DATE REC'D. BY REGISTRAR  |  |   |  | 25b. REGISTRAR              |  |
| HUBBARD FUNERAL HOME, INC.   |  |  |  |  |  | 4107 WILKENS AVE.  |  | MAR 1 1982   |  |   |  | Charles J. [Signature]      |  |





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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |   |  | 8 2 0 4 1 6 6   |  |
|--|--|---|--|---|--|
| 1. FOR STATE REGISTRAR   |  |   |  | REG. NO.  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>James A. Satchell</b>   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>February 6, 1982</b>                 |   | 2b. HOUR<br><b>11:30 PM</b>  |
| 3. SEX<br><b>Male</b>  | 4. RACE<br><b>Black</b>                    | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>2 8 17</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>64</b> YRS.   |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br><b>VA</b>  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b> | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.                               |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Maryland General Hospital</b>               |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)                                |  |
| 13a. STATE<br><b>MD</b>  |  | 13b. COUNTY   | 13c. CITY OR TOWN<br><b>Baltimore</b>  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS<br><b>2310 Druid Hill Ave.</b>   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>- - -</b>   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>- - -</b>   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>No</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>212-16-1353</b>  |  | 17. INFORMANT<br>ADDRESS<br><b>Inez Edmonds 2310 Druid Hill Ave.</b>                            |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Metastatic Carcinoma</b><br><b>1560</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>Carcinoma of Gall Bladder</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) |  |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).   |  |   |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>February 6, 1982</b> to <b>February 6, 1982</b> , that (I) (we) last saw the deceased alive on <b>February 6, 1982</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.   |  |   |  |   |  |
| 22b. SIGNATURE<br><i>Thomas MacPherson</i>   |  | DEGREE<br><b>M.D.</b>   |  | 22c. DATE SIGNED<br><b>February 6, 1982</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Thomas MacPherson M.D.</b>   |  | 22e. ADDRESS<br><b>c/o Maryland General Hospital</b>  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  | 23b. DATE<br><b>2/12/82</b>                | 23c. NAME OF CEMETERY OR CREMATORY<br><b>King Memorial Pk.</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Co. MD</b>                           |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Wm. C. March F/H</b>  |  | ADDRESS<br><b>1101 E. North Ave.</b>  |  | 25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE<br><b>FEB 8 1982 Thomas MacPherson</b> |  |



11-200

February 1982

Section II

Index

Continued on p. 112

Section II - General and Special

Section II - General and Special

Section II - General and Special

NOTICE



Section II - General and Special

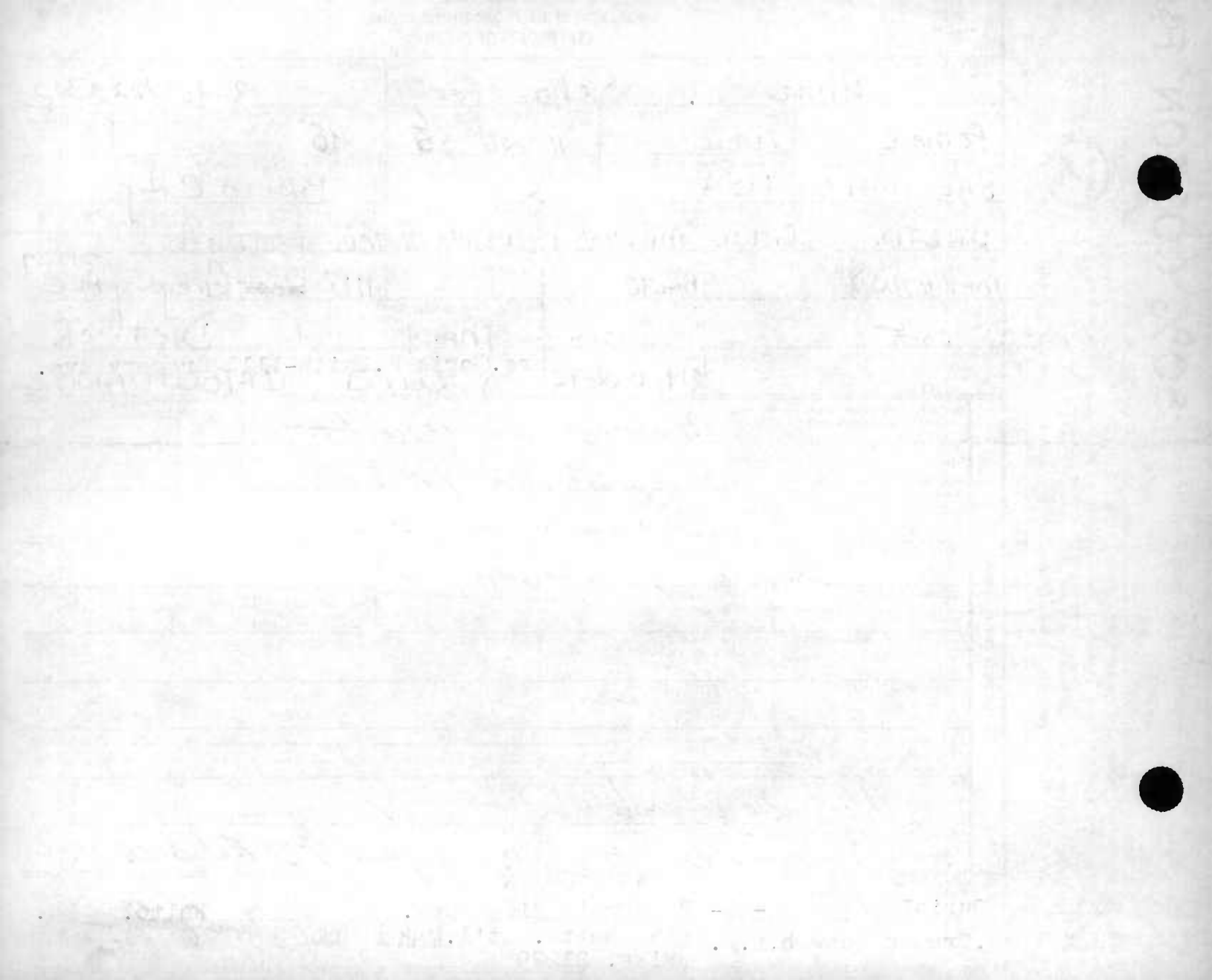
11-200 1982 Section II

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  |   |  |   |  |   |  | 8 2 0 4 1 6 7                                   |  |
|---|--|---|--|---|--|---|--|---|--|---|--|
| 1. FOR<br>STATE<br>REGISTRAR  |  | REG. NO.  |  |   |  |   |  |   |  |   |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  | FIRST MIDDLE LAST<br>Anna W. Schaeffer  |  |   |  | 2a. DATE OF DEATH   |  | MONTH DAY YEAR<br>2 23 1982   |  | 2b. HOUR<br>5:30 p.m.                           |  |
| 3. SEX<br>Female  |  | 4. RACE<br>White  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>11 26 86  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>95 YRS.  |  | IF UNDER 1 YEAR<br>MONTHS DAYS  |  | IF UNDER 24 HRS.<br>HOURS MIN.                  |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br>BALTIMORE   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTO CITY MD   |  |   |  |   |  |
| 10. CITY OR TOWN OF DEATH<br>BALTO.   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>CATON MANOR NURSING CENTER |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Housewife                   |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |   |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>MARYLAND  |  | 13b. COUNTY<br>BALTO  |  | 13c. CITY OR TOWN<br>BALTO.   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS<br>1118 Gregory Ave.  |  |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>John Weller   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE<br>Mary Diethick   |  | 16. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>No   |  |   |  |   |  |   |  |
| 16a. SOCIAL SECURITY NO.<br>219-10-5692   |  | 16b. ADDRESS<br>Mrs. Doris M. Smith-1118 Gregory Ave.<br>CATON MANOR  |  |   |  |   |  |   |  |   |  |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardiovascular arrest</u><br>4149<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Cerebral Heart Failure</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>Coronary artery Disease</u>          |  |   |  |   |  |   |  |   |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><u>Heute ST. Bleeding Uti.</u>   |  |   |  |   |  |   |  |   |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |  |   |  |   |  |   |  |   |  |
| 22b. SIGNATURE<br><u>Alejandro Morilla MD</u>   |  | DEGREE  |  | 22c. DATE SIGNED  |  |   |  |   |  |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>ALEXANDRO MORILLA MD   |  | 22e. ADDRESS<br>1900 Sulphur Spring Rd Balto 21221  |  |   |  |   |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial  |  | 23b. DATE<br>2-25-82  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Druid Ridge Cem.  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Balto. Nat'l. Pike, 21229                         |  |   |  |   |  |
| 24. FUNERAL DIRECTOR<br>G. Truman Schwab, P.A. 5151 Balto. Nat'l. Pike, 21229   |  |   |  |   |  |   |  |   |  |   |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of grade.

1 -  
FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

3 2 0 4 1 6 8

REG. NO.

|   |  |  |   |   |                                       |   |   |  |  |
|---|--|--|---|---|---------------------------------------|---|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>ELEANOR R. SCHANZE</b>  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>February 16, 1982</b>       |   |                                       | 2b. HOUR<br>M<br><b>M</b>   |   |  |  |
| 3 SEX<br><b>Female</b>  |  | 4 RACE<br><b>White</b>   |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>December 22, 1923</b>  |                                       | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>58</b> YRS  |   | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>     |                                       | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.   |   |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>1613 Sherwood Avenue</b> |   |   |                                       | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Homemaker</b>  |   | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13a. STATE<br><b>Maryland</b>   |  |  | 13b. COUNTY   |   | 13c. CITY OR TOWN<br><b>Baltimore</b> |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>John R. Lloyd</b>  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Mary B. Bowen</b> |   |                                       | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>Yes</b><br>16b. SOCIAL SECURITY NO.<br><b>216-14-4934</b> |   |  |  |
| 16c. ADDRESS<br><b>Mr. Jack L. Schanze 1613 Sherwood Avenue</b>   |  |  |   |   |                                       |   |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiopulmonary arrest</b><br><b>2030</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>hypercalcemia</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>multiple myeloma/Plasma Cell Leukemia</b><br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) |  |  |   |   |                                       |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   |   |                                       | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |                                       |   |   |  |  |
| 21d. INJURY OCCURRED<br>AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |                                       |   |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>July</b> 19 <b>78</b> to <b>Feb. 16</b> 19 <b>82</b> , that (I) (we) last saw the deceased alive on <b>Feb. 12</b> 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |  |   |   |                                       |   |   |  |  |
| 22b. SIGNATURE<br><b>Judith E Karp, MD</b>  |  |  |   | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |                                       |   |   | 22c. DATE SIGNED<br><b>2/16/82</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Judith Karp, M.D.</b>   |  |  |   | 22e. ADDRESS<br><b>Johns Hopkins Hospital</b>   |                                       |   |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(TYPE)<br><b>Cremation</b>   |  | 23b. DATE<br><b>2-17-82</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Loudon Park Crematory</b>  |                                       | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Maryland</b>   |   |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Ruck Towson Funeral Home, Inc.</b>   |  |  |   | ADDRESS<br><b>1050 York Road</b>  |                                       | 25a. DATE REC'D. BY REGISTRAR<br><b>FEB 18 1982</b>   |   | 25b. REGISTRAR'S SIGNATURE<br><b>James J. [Signature]</b>  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death and may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 27 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |              |   |  |   |  |  |  | 8 2 0 4 1 6 9                                |  |
|--|--|--|--------------|---|--|---|--|--|--|--|--|
| FOR<br>1. - STATE<br>REGISTRAR   |  | REG. NO.   |              |   |  |   |  |  |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  | FIRST<br>JOYCE   | MIDDLE<br>A. | LAST<br>SCHAUB  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>2 19 82 |   |  | 2b. HOUR<br>M  |  |  |  |
| 3 SEX<br>Female  |  | 4 RACE<br>White  |              | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>6 14 1943   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>38 YRS   |  | IF UNDER 1 YEAR<br>MONTHS DAYS   |  | IF UNDER 24 HRS.<br>HOURS MIN.               |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Virginia  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |              | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>        |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.                                       |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Baltimore City Hospital |              |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Housewife                   |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |  |  |
| 13a. STATE<br>Maryland   |  | 13b. CITY OR TOWN<br>Baltimore   |              | 13c. CITY OR TOWN<br>Dundalk  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS<br>1917 Quentin Road   |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>William Payne  |  |  |              | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Dora Hobbs   |  |   |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>No                     |  |  |  |
| 16b. SOCIAL SECURITY NO.<br>138-32-1372  |  |  |              | 17. INFORMANT<br>Francis L. Schaub  |  |   |  | ADDRESS<br>1917 Quentin Rd. Balto., MD. 21222  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>cardiopulmonary arrest</u><br><u>4960</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>b) <u>respiratory arrest</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>c) <u>SEVERE EXACERBATION OF BAD COPD</u> |  |  |              |   |  |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |  |              |   |  |   |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |              |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |              | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |  |   |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |              | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |  |  |  |  |
| 22a. I certify that (this hospital) attended the deceased from <u>2/17/82</u> , 19 <u>82</u> , to <u>2/19/82</u> , 19 <u>82</u> , that (we) lost<br>saw the deceased alive on <u>2/19/82</u> , 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, that (we) (did) (did not) view the body after death.   |  |  |              |   |  |   |  |  |  |  |  |
| 22b. SIGNATURE<br><u>mbz</u>   |  |  |              | DEGREE<br><u>MD</u><br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  |   |  | 22c. DATE SIGNED<br><u>2/19/82</u>   |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>C. M. B. A.</u>  |  |  |              | 22e. ADDRESS<br><u>BCH, DEPT OF MEDICINE, BALTO 21224</u>   |  |   |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Cremation  |  | 23b. DATE<br>2/23/1982   |              | 23c. NAME OF CEMETERY OR CREMATORY<br>Green Mount   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore Maryland                                |  | 23e. DATE REC'D. BY REGISTRAR 23f. REGISTRAR'S SIGNATURE<br><u>FEB 23 1982</u> <u>Thomas J. [Signature]</u>                |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME Duda-Ruck, Inc. ADDRESS<br>7922 Wise Avenue Dundalk, MD. 21222  |  |  |              |   |  |   |  |  |  |  |  |

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

|  |  |                         |   |  |  |   |  |  |   |   |  |   |  |  |
|--|--|-------------------------|---|--|--|---|--|--|---|---|--|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Doris L. Schaumburg</b>   |  |                         | 2a. DATE KNOWN OF DEATH<br>ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR <b>2 20 19 82</b>                                     |  |  | 2b. HOUR <b>M</b>   |  |  |   |   |  |   |  |  |
| 3. SEX<br><b>Female</b>  |  | 4. RACE<br><b>White</b> |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR <b>5-16-1927</b>                            |  | 6. AGE (IN YEARS)<br>LAST BIRTHDAY <b>54</b> YRS.   |  | 7c. DATE PRONOUNCED DEAD<br>MONTH DAY YEAR <b>2 20 19 82</b>   |   | 7d. HOUR <b>11:42 P. M.</b>                                     |  |   |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Kentucky</b>   |  |                         | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City,</b> MD.                              |   |  |   |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |  |                         | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Baltimore City Hospitals</b> |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Assembly</b>  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Western Elec.</b>                                       |   |  |   |  |  |
| 13a. STATE<br><b>Md.</b>   |  |                         | 13b. COUNTY<br><b>-</b>   |  |  | 13c. CITY OR TOWN<br><b>Baltimore</b>   |  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   |  | 13e. STREET ADDRESS<br><b>4526 Manor View Rd.</b> |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>unknown</b>   |  |                         |   |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>unknown</b>   |  |  |   |   |  |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br><b>no</b>   |  |                         |   | 16b. SOCIAL SECURITY NO.<br><b>217-22-3058</b>                                 |  |   |  | 17. INFORMANT<br>ADDRESS <b>same address</b><br><b>Charles Schaumburg (husband)</b>                      |   |   |  |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br><b>9654</b> IMMEDIATE CAUSE (a) <b>Gunshot wound to Chest</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____   |  |                         |   |  |  |   |  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                    |  |   |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).  |  |                         |   |  |  |   |  |  |   |   |  |   |  |  |
| 19a. DATE OF OPERATION   |  |                         |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                              |  |   |  | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                      |   |   |  |   |  |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |  |                         |   | 21b. TIME OF INJURY<br>HOUR <b>10:32 P.M.</b> MONTH DAY YEAR <b>2 20 19 82</b> |  |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)<br><b>subject was shot</b> |   |   |  |   |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>  |  |                         |   | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)<br><b>Bar</b>      |  |   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br><b>40 S. East St., Baltimore, Maryland</b>          |   |   |  |   |  |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> . |  |                         |   |  |  |   |  |  |   |   |  |   |  |  |
| ACTUAL SIGNATURE <b>Virginia L. Dolan</b>  |  |                         |   | TITLE (SPECIFY)<br><b>Assistant</b> M.D.                                       |  |   |  | DATE SIGNED <b>2-21-82</b>   |   |   |  |   |  |  |
| EXAMINER'S NAME (TYPE OR PRINT)<br><b>Virginia L. Dolan, M.D.</b>  |  |                         |   | ADDRESS<br><b>111 Penn Street</b>  |  |   |  |  |   |   |  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |  |                         |   | 23b. DATE<br><b>2/24/82</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Woodlawn Cemetery</b>  |  |  |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Balto. Md.</b> |  |   |  |  |
| 24. FUNERAL DIRECTOR<br><b>Schimunek Funeral Home, Inc.</b><br><b>3331 Brehms Lane, Balto. Md. 21213</b>   |  |                         |   |  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>FEB 23 1982</b>   |  | 25b. REGISTRAR<br><b>James J. [Signature]</b>  |   |   |  |   |  |  |

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201



RECEIVED

DOUGLAS COUNTY

1911

Wagon & Horse

James J. [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 4 1 7 1

REG. NO.

|   |  |   |  |   |
|---|--|---|--|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>ELIZABETH M. SCHEERER</b>  |  | 2a. DATE OF DEATH<br>MONTH <b>02</b> DAY <b>08</b> YEAR <b>82</b>   |  | 2b. HOUR<br><b>8:45</b> M   |
| 3. SEX<br><b>Fem.</b>   | 4. RACE<br><b>Cau.</b>   | 5. DATE OF BIRTH<br>MONTH <b>10</b> DAY <b>15</b> YEAR <b>05</b>  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>76</b> YRS.  | IF UNDER 1 YEAR<br>MONTHS <b>00</b> DAYS <b>00</b>                            |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br><b>Md.</b>  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.  |   |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br><b>UNION MEMORIAL HOSPITAL</b>  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Homemaker</b>  | 12b. KIND OF BUSINESS OR INDUSTRY  |   |
| 13a. STATE<br><b>Md.</b>  | 13b. COUNTY<br><b>-</b>  | 13c. CITY OR TOWN<br><b>Balto.</b>  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            | 13e. STREET ADDRESS<br><b>5837 Belair Rd.</b>                                 |
| 14. FATHER'S NAME<br>FIRST <b>Lee</b> MIDDLE <b>Charlton</b> LAST <b>Lee</b>  | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>Elizabeth</b> MIDDLE <b>Hopwood</b> LAST <b>Hopwood</b>   |   |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>no</b>   | 16b. SOCIAL SECURITY NO.<br><b>216-03-4882D</b>  | 17. INFORMANT ADDRESS<br><b>Robert N. Selvage 420 Scenic Dr. Harrisburg, Pa.</b>  |  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Resp arrest</b><br><b>4292</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>Massive stroke CVA</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>ASCD</b>  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>24 hrs.</b><br><b>yrs.</b> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)<br><b>DM</b>   |  |   |  |   |
| 19a. DATE OF OPERATION  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>2-8</b> , 19 <b>82</b> , to <b>2-8</b> , 19 <b>82</b> . That (I) (we) lost saw the deceased alive on <b>never</b> 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |  |   |  |   |
| 22b. SIGNATURE<br><b>Patricia Walsh</b>   | DEGREE <b>MD</b><br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | 22c. DATE SIGNED<br><b>2-8-82</b>   |  |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>PATRICIA WALSH M.D.</b>   | 22e. ADDRESS<br><b>UNION MEMORIAL HOSPITAL</b>   |   |  |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   | 23b. DATE<br><b>2-11-82</b>  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Parkwood Cem.</b>  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Balto. Md.</b>  |   |
| 24. FUNERAL DIRECTOR<br>NAME <b>John C. Miller Inc.</b> ADDRESS <b>6415 Belair Rd.</b>  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>FEB 11 1982</b>   | 25b. REGISTRAR'S SIGNATURE<br><b>Frances Jan Nathan</b>  |   |

UNITED STATES DEPARTMENT OF JUSTICE  
FEDERAL BUREAU OF INVESTIGATION

MEMORANDUM FOR THE DIRECTOR

SUBJECT: [Illegible]

REFERENCE: [Illegible]

DATE: [Illegible]

BY: [Illegible]

TO: [Illegible]

FOR THE DIRECTOR: [Illegible]

DATE: [Illegible]

BY: [Illegible]

DATE: [Illegible]

UNITED STATES DEPARTMENT OF JUSTICE  
FEDERAL BUREAU OF INVESTIGATION

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 4 1 7 2

REG. NO.

1. FOR  
STATE  
REGISTRAR

|   |  |  |  |   |  |   |  |   |  |   |  |
|---|--|--|--|---|--|---|--|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>SCHAEFFER, J. T. MORRIS</b>   |  | FIRST<br><b>T.</b>   |  | MIDDLE<br><b>MORRIS</b>   |  | LAST<br><b>SCHAEFFER</b>  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>2 3 82</b>                                      |  | 2b. HOUR<br>MIN.<br><b>1:30 AM</b>                      |  |
| 3. SEX<br><b>MALE</b>   |  | 4. RACE<br><b>WHITE</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>August 25, 1889</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>MONTHS YRS<br><b>93 74</b>                                   |  | IF UNDER 1 YEAR<br>MONTHS DAYS  |  | IF UNDER 24 HRS<br>HOURS MIN.                           |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>CITY</b> MD.   |  |   |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Bon Secours Hospital</b> |  |   |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Postal Service</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>U.S. Gov't.</b> |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>STATE<br><b>Maryland</b> |  | CITY OR TOWN<br><b>Baltimore</b>   |  | 13c. CITY OR TOWN<br><b>Timonium</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>163 Springside Drive 21093</b>                                  |  |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Charles J. Scheffer</b>  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Annie Schisler</b>   |  |   |  |   |  |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>                                   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>220-44-6346</b>  |  | 17. INFORMANT ADDRESS<br><b>Mrs. Beryl S. McDonough 315 Montrose Avenue</b>   |  |   |  |   |  |   |  |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY:

4275

IMMEDIATE CAUSE (a) **CARDIAC ARREST**

DUE TO, OR AS A CONSEQUENCE OF

(b) **ADVANCED****VASCULAR DISEASE****YEARS**

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

MEDICAL CERTIFICATION

|   |  |  |  |  |  |  |  |
|---|--|--|--|--|--|--|--|
| 19a. DATE OF OPERATION<br><b>1-11-82</b>  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>      |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost<br>saw the deceased alive on <b>2-3</b> , 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |  |  |
| 22b. SIGNATURE<br><b>William O. Richards</b>  |  | DEGREE<br><b>M.D.</b>  |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br><b>2-3-82</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>William O. Richards</b>   |  | 22e. ADDRESS<br><b>Box 78 Univ. Hosp.</b>                              |  |  |  |  |  |

|  |  |                              |  |   |  |   |  |
|--|--|------------------------------|--|---|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>                                  |  | 23b. DATE<br><b>2-6-1982</b> |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Parkwood</b> |  | 23d. LOCATION<br>CITY OR TOWN COUNTY<br><b>Baltimore Maryland</b> |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Ruck Towson Funeral Home, Inc. Towson, Maryland</b> |  |                              |  | 25a. DATE REC'D. BY REGISTRAR<br><b>FEB 5 1982</b>    |  | 25b. REGISTRAR'S SIGNATURE<br><b>R. J. [Signature]</b>            |  |

REPORT DATES

REPORT DATES

REPORT DATES

REPORT DATES

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REPORT DATES

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| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |  |  |  |  |  |  |  |  |  | REG. NO. 04173  |  |
|--|--|--|--|--|--|--|--|--|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>CORY A. SCHEPERS</b>  |  |  |  |  |  |  |  |  |  | 2a. DATE KNOWN OF DEATH <b>2-5-82</b>   |  |
| 1. SEX <b>male</b> 4. RACE <b>white</b> 5. DATE OF BIRTH <b>Nov. 25, 1981</b> 6. AGE (IN YEARS) <b>2</b> 7. IF UNDER 1 YR. <b>2</b> 8. IF UNDER 24 HRS. <b>10</b>  |  |  |  |  |  |  |  |  |  | 2c. DATE PRONOUNCED DEAD <b>2-5-82</b>  |  |
| 7b. CITIZEN OF WHAT COUNTRY? <b>USA</b> 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>   |  |  |  |  |  |  |  |  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b>  |  |
| 10. CITY OR TOWN OF DEATH <b>Baltimore</b> 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION <b>Union Memorial Hospital</b>   |  |  |  |  |  |  |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Infant</b>                             |  |
| 13a. STATE <b>Md.</b> 13b. COUNTY <b>Baltimore</b> 13c. CITY OR TOWN <b>Middle River</b>   |  |  |  |  |  |  |  |  |  | 13d. INSIDE CITY LIMITS? <b>YES</b> 13e. STREET ADDRESS <b>42 D. Fenway South</b>                       |  |
| 14. FATHER'S NAME <b>Patrick Ayers</b> 15. MOTHER'S MAIDEN NAME <b>Lida Schepers</b>   |  |  |  |  |  |  |  |  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? <b>no</b> 16b. SOCIAL SECURITY NO. <b>None</b>             |  |
| 17. INFORMANT <b>Lida Schepers</b> ADDRESS <b>Same</b>   |  |  |  |  |  |  |  |  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Sudden Infant Death Syndrome</b><br>7980<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b) _____<br>(c) _____   |  |  |  |  |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).  |  |  |  |  |  |  |  |  |  |   |  |
| 19a. DATE OF OPERATION _____ 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? _____   |  |  |  |  |  |  |  |  |  | 20. AUTOPSY? <b>YES</b> <input checked="" type="checkbox"/> <b>NO</b> <input type="checkbox"/>          |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH _____  |  |  |  |  |  |  |  |  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR _____  |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |  |  |  |  |  |  |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) _____                                       |  |
| 21f. LOCATION STREET _____ CITY OR TOWN _____ COUNTY _____ STATE _____   |  |  |  |  |  |  |  |  |  |   |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |  |  |  |  |  |  |  |  |   |  |
| ACTUAL SIGNATURE <b>Margarita A. Korell</b> TITLE (SPECIFY) <b>Assistant</b> MEDICAL EXAMINER  |  |  |  |  |  |  |  |  |  | DATE SIGNED <b>2-5-82</b>   |  |
| EXAMINER'S NAME (TYPE OR PRINT) <b>Margarita A. Korell, M.D.</b> ADDRESS <b>111 Penn Street</b>  |  |  |  |  |  |  |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>  |  |  |  |  |  |  |  |  |  | 23b. DATE <b>2/8/82</b>   |  |
| 23c. NAME OF CEMETERY OR CREMATORY <b>Gardens of Faith</b>   |  |  |  |  |  |  |  |  |  | 23d. LOCATION CITY OR TOWN <b>Baltimore</b> COUNTY _____ STATE <b>Maryland</b>                          |  |
| 24. FUNERAL DIRECTOR <b>Burgee Funeral Home</b> ADDRESS <b>3631 Falls Road 21211</b>   |  |  |  |  |  |  |  |  |  | 25a. DATE REC'D. BY REGISTRAR <b>FEB 9 1982</b> 25b. REGISTRAR'S SIGNATURE <b>Thomas J. [Signature]</b> |  |

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR RECORDS. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201



10 3

Nov. 26, 1941

18

Received

Infants

W. J. Conway, Jr.

Infants

Infants

Infants

Infants

Infants

to

Infants

Infants

Infants

Infants

Infants

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |   |  | 8 2 0 4 1 7 4   |  |  |  |
|---|--|---|--|---|--|--|--|
| FOR STATE REGISTRAR   |  |   |  | REG. NO.  |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>MARTHA T SCHÉPER</b>   |  |   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR <b>2-10-82</b>  |  | 2b. HOUR<br><b>6:45 P.M.</b>   |  |
| 3. SEX<br><b>FEMALE</b>   |  | 4. RACE<br><b>W</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR <b>8 18 97</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>84</b> YRS   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>UNKNOWN</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE City</b> MD.  |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>LUTHERAN HOSPITAL</b> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>NONE</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13a. STATE<br><b>MD</b>   |  | 13b. COUNTY   |  | 13c. CITY OR TOWN<br><b>BALTIMORE</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST   |  | 13e. STREET ADDRESS<br><b>3313 POPLAR ST</b>  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>N</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>212-098-415A</b>   |  | 17. INFORMANT<br>ADDRESS<br><b>Tom. L. Records</b>  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Sepsis</b><br><b>2500</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>Diabetes</b><br>DUE TO, OR AS A CONSEQUENCE OF (c)                   |  |   |  |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:<br><b>Bleeding ulcer</b>   |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a. I certify that (if this hospital) attended the deceased from <b>02/03/82</b> , 19 <b>82</b> , to <b>02/10/82</b> , 19 <b>82</b> , that (if (we) lost saw the deceased alive on <b>02/10/82</b> , 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |  |   |  |  |  |
| 22b. SIGNATURE<br><b>Sissay Awoke</b> MD<br>DEGREE  |  |   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                  |  | 22c. DATE SIGNED<br><b>2/10/82</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>SISSAY AWOKE</b>  |  |   |  | 22e. ADDRESS<br><b>Lutheran Hospital</b>  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>   |  | 23b. DATE<br><b>2/12/82</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Parkwood</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>BALTO MD</b>  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>EVANS</b>  |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>FEB 16 1982</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Frances Jan Nathan</b>  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  |   |  |  |   |  |   | REG. NO. |  |
|--|--|---|--|---|--|--|---|--|---|----------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>MERRITT L. SCHILDTKNECHT  |  |   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>FEBRUARY 24, 1982   |  |   | 2b. HOUR<br>06:04AM  |   |          |  |
| 3. SEX<br>Male   |  | 4. RACE<br>White  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>9 24 1919   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>62 YRS.   |   | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.   |   |          |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.                           |   |  |   |          |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>THE JOHNS HOPKINS HOSPITAL |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Fireman/Retired  |   | 12b. KIND OF BUSINESS OR INDUSTRY<br>U.S. Gov't  |   |          |  |
| 13a. STATE<br>Maryland   |  |   |  |   | 13b. COUNTY<br>Harford   |  | 13c. CITY OR TOWN<br>Bel Air  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |          |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Rodney Schildtknecht   |  |   |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Mabel Fowler  |  |   |  |   |          |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>Yes WW-II  |  |   |  |   | 16b. SOCIAL SECURITY NO.<br>198-01-2013  |  | 17. INFORMANT<br>ADDRESS<br>Hagerstown, Maryland 21740<br>Irene Schildtknecht, 1601 Fountain Green Rd., |  |   |          |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>respiratory arrest</u><br>5789 DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>aspiration</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>GI bleed</u><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>2 hrs<br>3 hrs |  |   |  |   |  |  |   |  |   |          |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |   |  |   |  |  |   |  |   |          |  |
| 19a. DATE OF OPERATION   |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |          |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |   |  |   |          |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |   |  |   |          |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>2/24</u> 19 <u>82</u> , to <u>2/24</u> 19 <u>82</u> , that (I) (we) last saw the deceased alive on <u>2/24</u> 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we did, last not view the body after death.)  |  |   |  |   |  |  |   |  |   |          |  |
| 22b. SIGNATURE<br>SIEGERS, M   |  |   |  |   | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br>2/24/82   |  |   |          |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>SIEGERS, M  |  |   |  |   | 22e. ADDRESS<br>Johns Hopkins Hospital   |  |   |  |   |          |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Removal/Burial  |  |   | 23b. DATE<br>2/27/1982   |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Rest Haven Chapel, Inc.  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Hagerstown Washington Md.                                 |  |   |          |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br>Tarring Funeral Home, P.A., Aberdeen, Md. 21001-3399   |  |   |  |   | 25a. DATE REC'D. BY REGISTRAR<br>FEB 26 1982   |  | 25b. REGISTRAR'S SIGNATURE<br>James J. [Signature]  |  |   |          |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and the death certificate must be rechecked and signed.

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |   |   |   |   |  |
|---|---|---|---|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Samuel Schlossberg</b>   |   |   | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>FEBRUARY 21, 1982</b>  |   | 2b. HOUR<br><b>5:40 AM</b>   |
| 3. SEX<br><b>MALE</b>   | 4. RACE<br><b>WHITE</b>   | 5. DATE OF BIRTH<br><b>MAY 28, 1889</b>   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>92</b>  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.                                 |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN)<br><b>RUSSIA</b>  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.                                   |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>3307 DEVONSHIRE DR.</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK OR MAIN SOURCE OF LIVING LIFE)<br><b>FOREMAN IRON WORKER</b> | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>METAL</b>   |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>MARYLAND</b>   |   | 13b. COUNTY<br><b>BALTIMORE</b>   | 13c. CITY OR TOWN<br><b>BALTIMORE</b>   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS<br><b>3307 DEVONSHIRE DR. (21215)</b>  |
| 14. FATHER'S NAME<br><b>MICHEL</b> MIDDLE<br><b>SCHLOSSBERG</b>   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST<br><b>UNKNOWN</b> MIDDLE<br><b>UNKNOWN</b> LAST<br><b>UNKNOWN</b>   |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br><b>NO</b>  |   | 16b. SOCIAL SECURITY NO.<br><b>212-05-5098</b>  | 17. INFORMANT ADDRESS<br><b>(21215) MRS. FLORENCE BROWN 3307 DEVONSHIRE DR.</b>                     |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>acute myocardial infarction</b><br>4100<br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>arteriosclerotic Cardio Vasc Dis</b><br>DUE TO, OR AS A CONSEQUENCE OF (c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>7 minutes</b>        |   |   |   |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).  |   |   |   |   |  |
| 19a. DATE OF OPERATION  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                      |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |  |
| 22a. I certify that (I) (the hospital) attended the deceased from <b>Feb 28</b> , 19 <b>82</b> , to <b>Feb 21</b> , 19 <b>82</b> , that (I) (we) lost<br>saw the deceased alive on <b>Feb 8</b> , 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (we) did not view the body after death. |   |   |   |   |  |
| 22b. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>SAMUEL TOMPAKOV</b>   |   | 22c. ADDRESS<br><b>7211 PARK HEIGHTS AVE.</b>   |   | 22d. DATE SIGNED<br><b>2/21/82</b>  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>   |   | 23b. DATE<br><b>2/22/82</b>   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>FORBAND CEMETERY</b>                                       |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>ROSEDALE, MD. BALTO. MD</b>   |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>SOL LEVINSON &amp; BROS</b><br>6010 REISTERSTOWN RD. BALTIMORE, MD. (21215)  |   |   | 25a. DATE REC'D BY REGISTRAR<br><b>FEB 24 1982</b>  |   |  |

NOTICE



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1/2



FEB 24 1968



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

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1- FOR  
STATE  
REGISTRAR

REG. NO.

|   |  |  |   |   |  |  |
|---|--|--|---|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <u>WILMA Amelia SCHMIDT</u>   |  |  | 2a. DATE OF DEATH<br>MONTH <u>2</u> DAY <u>6</u> YEAR <u>82</u>                         |   | 2b. HOUR<br><u>9:50 AM</u>   |  |
| 3. SEX<br><u>Female</u>   | 4. RACE<br><u>White</u>  | 5. DATE OF BIRTH<br>MONTH <u>12</u> DAY <u>25</u> YEAR <u>1887</u>   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><u>94</u>  | 6. UNDER 1 YEAR<br>MONTHS <u>0</u> DAYS <u>0</u> HOURS <u>0</u> MINS <u>0</u><br>6. UNDER 24 HRS<br>HOURS <u>0</u> MINS <u>0</u> |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><u>Latvia</u>  | 7b. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.</u>  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>    |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><u>BALTIMORE City MD</u>                                |  |  |
| 10. CITY OR TOWN OF DEATH<br><u>Balto</u>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><u>MERCY Hosp</u> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><u>House Keeper</u> |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><u>Retired</u>  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE <u>Md.</u> 13a. COUNTY <u>Balto.</u>   |  |  | 13b. CITY OR TOWN<br><u>Balto.</u>  | 13c. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13d. STREET ADDRESS<br><u>2211 Taylor Avenue</u>   |  |
| 14. FATHER'S NAME<br>FIRST <u>William</u> MIDDLE <u>Schmidt</u> LAST <u>Schmidt</u>   |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST <u>Louise</u> MIDDLE <u></u> LAST <u></u>             |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <u>No</u>  |  | 16b. SOCIAL SECURITY NO.<br><u>215-32-2165</u>   |   | 17. INFORMANT<br><u>Herbert W.L. Burhenn Jr.</u>  |  |  |
|   |  |  |   | ADDRESS <u>313 Arrow Drive Signal Mt., Tenn.</u>  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br><u>5728</u> IMMEDIATE CAUSE (a) <u>Cardiac Shock</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Congestive Heart Failure</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>Lower Failure / Renal Failure</u><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>2 days</u><br><u>Weeks</u><br><u>Weeks</u> |  |  |   |   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <u></u>  |  |  |   |   |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><u>P.M.</u> <u>19</u>   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b. PART I OR PART 2)                  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>1/21</u> , 19 <u>82</u> , to <u>2/6</u> , 19 <u>82</u> , that (I) (we) last saw the deceased alive on <u>2/6</u> , 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |  |   |   |  |  |
| 22b. SIGNATURE<br><u>R. Maggin</u>  |  | DEGREE <u>MD</u><br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   | 22c. DATE SIGNED<br><u>2/6/82</u>   |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>R. MAGGIN</u>   |  | 22e. ADDRESS<br><u>MERCY HOSPITAL, BALTO, MD.</u>  |   |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY) <u>Burial</u>  |  | 23b. DATE<br><u>2-8-82</u>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Immanuel Luth Cem.</u>                                 |  | 23d. LOCATION<br>CITY OR TOWN <u>Balto. Md.</u> COUNTY STATE   |
| 24. FUNERAL DIRECTOR<br><u>John C. Miller Inc-6415 Belvoir Rd.-21206</u>  |  |  |   | 25a. DATE REC'D. BY REGISTRAR<br><u>FEB 8 1982</u>  |  | 25b. REGISTRAR'S SIGNATURE<br><u>James J. [Signature]</u>  |

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 IN YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED IN THE DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH-17  
(VR 15 ME (5))  
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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

|   |  |                  |  |  |  |   |  |   |  |
|---|--|------------------|--|--|--|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Katherine Eleanor Schroedl   |  |                  |  | 2a. DATE KNOWN OF DEATH<br>ESTIMATED<br>MONTH DAY YEAR<br>2 21 19 82   |  |   |  | 2b. HOUR<br>M<br>A. M   |  |
| 3. SEX<br>Female  |  | 4. RACE<br>White |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>10/15/1894                       |  | 6. AGE (IN YEARS)<br>(LAST BIRTHDAY)<br>87 YRS.                               |  | 7. IF UNDER 1 YR.<br>MONTHS DAYS HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland   |  |                  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.                                 |  |   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |
| 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City, MD.   |  |                  |  | 10. CITY OR TOWN OF DEATH<br>Baltimore                                 |  |   |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>4000 Woodlea Avenue                           |  |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Dressmaker   |  |                  |  | 12b. KIND OF BUSINESS OR INDUSTRY                                      |  |   |  | 13. DATE PRONOUNCED DEAD<br>MONTH DAY YEAR<br>2 21 19 82  |  |
| 13a. STATE<br>Maryland  |  |                  |  | 13b. COUNTY<br>-----   |  | 13c. CITY OR TOWN<br>Baltimore  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |
| 13e. STREET ADDRESS<br>4000 Woodlea Ave. 21206  |  |                  |  | 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Conrad E. Ripperger          |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Mary E. Zittinger  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br>No   |  |                  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>220,44,5139 |  | 17. INFORMANT<br>ADDRESS<br>Eleanor S. Davis---Same as 13e                    |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Arteriosclerotic Cardiovascular Disease</u><br><u>4292</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last:<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                  |  |                  |  |  |  |   |  |   |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).   |  |                  |  |  |  |   |  |   |  |
| 19a. DATE OF OPERATION  |  |                  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                      |  |   |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |  |                  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |  |   |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |                  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)            |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                             |  |   |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . |  |                  |  |  |  |   |  |   |  |
| ACTUAL SIGNATURE<br><u>Virginia L. Dolan</u>  |  |                  |  | TITLE (SPECIFY)<br>M.D. Assistant MEDICAL EXAMINER                     |  |   |  | DATE SIGNED<br>2-21-82  |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)<br>Virginia L. Dolan, M.D.   |  |                  |  | ADDRESS<br>111 Penn Street   |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Cremation   |  |                  |  | 23b. DATE<br>2/22/1982   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Green Mount Crematory                   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore Maryland  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Walter Brooks Bradley Inc.  |  |                  |  |  |  | ADDRESS<br>Balto., Md. 21222  |  | 25a. DATE REC'D. BY REGISTRAR<br>FEB 25 1982  |  |
|   |  |                  |  |  |  | 25b. REGISTRAR'S SIGNATURE<br><u>James J. Nathan</u>                          |  |   |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed within 72 hours after death. retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 4 1 7 9

REG. NO.

|   |   |  |   |  |  |
|---|---|--|---|--|--|
| 1 DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br>ARTHUR W. SCHULTZ   |   |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>02-04-82  |  | 2b. HOUR<br>3 <sup>35</sup> PM                     |
| 3 SEX<br>MALE   | 4 RACE<br>CAUCASIAN   | 5. DATE OF BIRTH MONTH DAY YEAR<br>06-13-16  | 6 AGE (IN YEARS LAST BIRTHDAY)<br>65 YRS  | IF UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 24 HRS HOURS MIN.                            |  |
| 7a. BIRTHPLACE (COUNTRY)<br>MD  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | BALTIMORE CITY OR COUNTY OF DEATH City<br>BALTIMORE COUNTY MD.                                  |  |  |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>903 COOKS LANE |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Retired Salesman            |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Balt G & E Co |
| 13a. STATE<br>MD  | 13b. COUNTY<br>BALTIMORE  | 13c. CITY OR TOWN<br>BALTO   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS<br>903 COOKS LANE  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>JOHN F. SCHULTZ  |   | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>MARY <del>HAH</del> VOLLMERHAUSEN  |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) NO   |   | 16b. SOCIAL SECURITY NO.<br>212-05-3831  |   | 17. INFORMANT ADDRESS<br>MEDICAL RECORDS BON SECOURS Hosp                            |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) ACUTE MYOCARDIAL INFARCTION 4100 MINUTES<br>DUE TO, OR AS A CONSEQUENCE OF (b) CORONARY HEART DISEASE YEARS<br>(ASCVD)<br>DUE TO, OR AS A CONSEQUENCE OF (c)                           |   |  |   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: C.O.P.D. - HYPERTENSION.   |   |  |   |  |  |
| 19a. DATE OF OPERATION  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |   | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                       |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 4-16 19 81, to 11-03 19 81, that (I) (we) lost<br>saw the deceased alive on 11-03 19 81, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |   |  |   |  |  |
| 27b. SIGNATURE<br>Oscar E. Ferdinandini MD  |   | DEGREE<br>MD   |   | 27c. DATE SIGNED<br>2-04-82  |  |
| 27d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>OSCAR E. FERNANDINI  |   | 27e. ADDRESS<br>5550 BALTO. NTAL. PIKE BALTO. MD   |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Cremation  |   | 23b. DATE<br>2/6/82  |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Greenmount                                     |  |
| 24. FUNERAL DIRECTOR NAME<br>Leonard J Ruck Inc.  |   | ADDRESS<br>Baltimore, Maryland   |   | 25a. DATE REC'D. BY REGISTRAR<br>FEB 5 1982  |  |
|   |   |  |   | 25b. REGISTRAR'S SIGNATURE<br>[Signature]  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the health officer with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

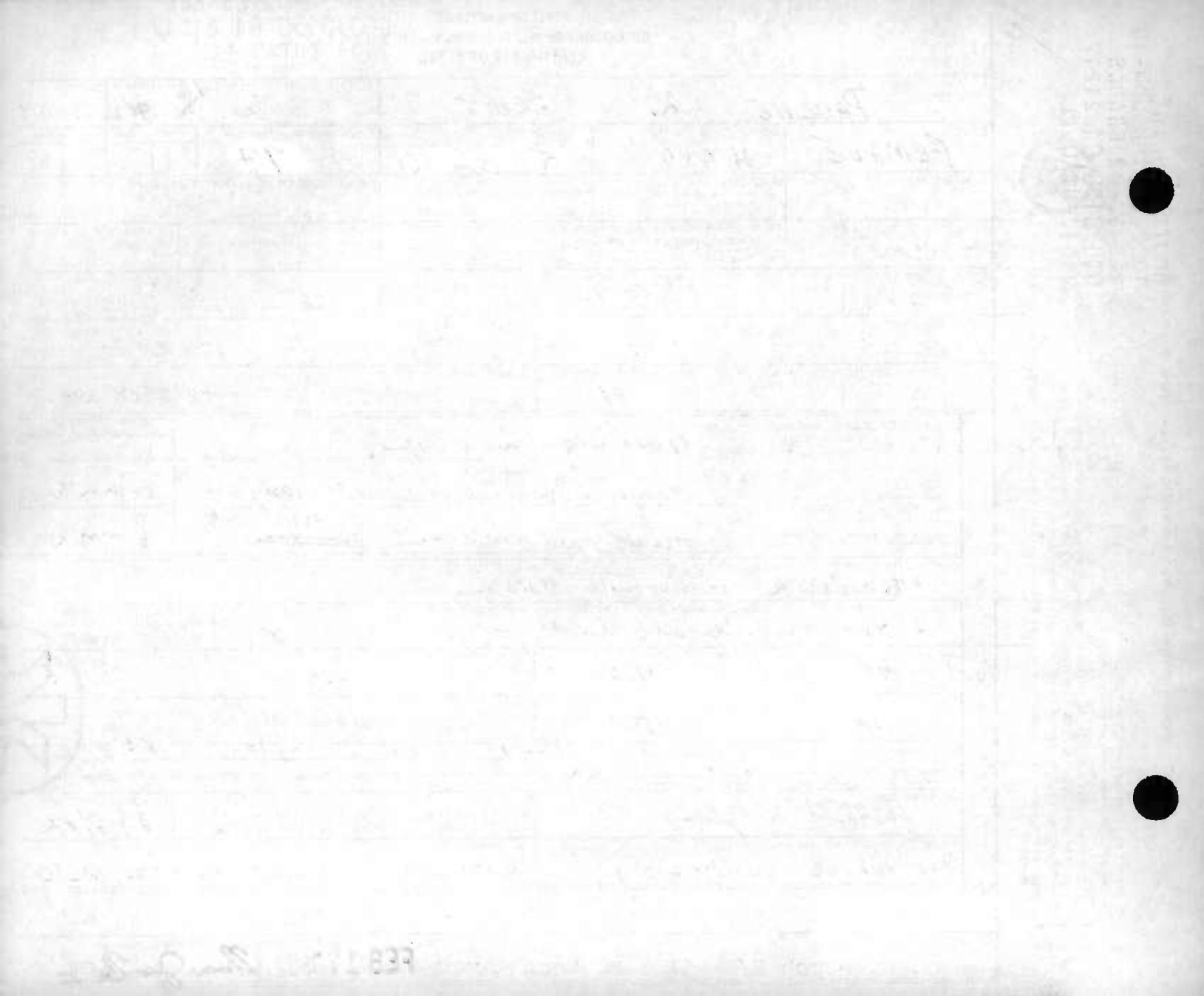
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  | REG. NO. 82 04180   |  |   |  |
|--|--|---|--|---|--|---|--|
| 1. FOR STATE REGISTRAR   |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR 2b. HOUR   |  |   |  |
| 1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Alice E. Scott   |  |   |  | FEB. 2/14/82 3:00 PM  |  |   |  |
| 3 SEX Female   |  | 4 RACE NEGRO  |  | 5 DATE OF BIRTH MONTH DAY YEAR 10 20 14   |  | 6 AGE (IN YEARS LAST BIRTHDAY) 67 YRS   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Wash. D.C.   |  | 7b. CITIZEN OF WHAT COUNTRY? USA  |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH City - Baltimore MD.  |  |
| 10 CITY OR TOWN OF DEATH Baltimore   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Bon Secours Hospital |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) CLERK   |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |   |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |   |  |
| 13a. STATE Maryland  |  | 13b. COUNTY BALTIMORE   |  | 13c. STREET ADDRESS 3305 FAIRVIEW AVE. 21216  |  |   |  |
| 14 FATHER'S NAME FIRST MIDDLE LAST UNKNOWN   |  |   |  | 15. MOTHER'S M maiden NAME FIRST MIDDLE LAST UNKNOWN  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) UNKNOWN  |  | 16b. SOCIAL SECURITY NO. 577-26-4359  |  | 17 INFORMANT ADDRESS THELMA WILLIAMS/2113 DRUID HILL AVE  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) UREMIA SYNDROME<br>4039<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) NEPHROSCLEROSIS<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>1 YEAR<br>15 YEARS |  |   |  |   |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (c)<br>LEFT CEREBRAL THROMBOSIS; CONGESTIVE HEART FAILURE   |  |   |  |   |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |   |  |
| 22a. I certify that (I) (the hospital) attended the deceased from NOVEMBER 81 to FEB 14, 1982, that (I) (we) lost saw the deceased alive on 2/13/82, 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                |  |   |  |   |  |   |  |
| 22b. SIGNATURE Howard Gendason MD.   |  | DEGREE MD.  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>              |  | 22c. DATE SIGNED 2/15/82  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) HOWARD GENDASON MD.  |  |   |  | 22e. ADDRESS 9 LIGHT ST. BALTO MD. 21202  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL   |  | 23b. DATE 02/18/82  |  | 23c. NAME OF CEMETERY OR CREMATORY MD NATL MEM PARK   |  | 23d. LOCATION LAUREL COUNTY MARYLAND  |  |
| 24 FUNERAL DIRECTOR NAME MARSHALL W JONES, JR/4101 EDMONDSON AVE   |  |   |  | 25a. DATE REC'D. BY REGISTRAR FEB 18 1982   |  | 25b. REGISTRAR'S SIGNATURE  |  |



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|--|--|--|--|---|--|--|--|
| Item 2a G 564 2/19/82 GAB  |  | STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  | 120430 02 CRANKS<br>00038150 01 21217<br>2401 EUTAW PL  |  | 8 1  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  | FIRST MIDDLE LAST<br>PAULINE R. SCOTT  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>Feb. 15 1982  |  | 2b. HOUR<br>6:10 AM  |  |
| 3. SEX<br>FEMALE   |  | 4. RACE<br>NEGRO   |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>4 5 07   |  | 6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS HOURS MIN.<br>74 YRS.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>W. Va.  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.   |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>North Charles General   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>MD   |  | 13b. COUNTY<br>Baltimore   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 13e. STREET ADDRESS<br>3028 W. North Avenue  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Samuel Tibbs   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Helen Debenger  |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>No   |  | 16b. SOCIAL SECURITY NO.<br>N/A  |  | 17. INFORMANT ADDRESS<br>Mary Waters 3907 Forest Park Ave.  |  |  |  |
| MEDICAL CERTIFICATION  |  | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Cardio-respiratory arrest<br>7070<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF (b) Multiple decussatus ulcer with sepsis 6 months<br>DUE TO, OR AS A CONSEQUENCE OF (c) Organic brain syndrome with sepsis 6 months |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
|  |  | PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br>Atherosclerotic cardiovascular disease   |  |   |  |  |  |
|  |  |  |  |   |  |  |  |
| 19a. DATE OF OPERATION<br>2/3/82   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br>Debridement of ulcer flap  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)<br>N/A |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>N/A   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)<br>N/A   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> ON VEHICLE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>            |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)<br>N/A  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br>N/A  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from above, (I) (we) (did) (did not) view the body after death.  |  | 10/22/81   |  | 19 81   |  | 2/16 82  |  |
| 22b. SIGNATURE<br>Chatchaval Vutiganon   |  | DEGREE   |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>                  |  | 22c. DATE SIGNED<br>2/16/82  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>CHATCHAVAL VUTIGANON  |  | 22e. ADDRESS<br>NORTH CHARLES GENERAL HOSPITAL, BALTO.   |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial  |  | 23b. DATE<br>2/19/82   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Mt. Auburn Cem.   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore MD   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Wm. C. March F/H   |  | ADDRESS<br>1101 E. North Ave.  |  | 25a. DATE REC'D. BY REGISTRAR<br>FEB 17 1982  |  | 25b. REGISTRAR'S SIGNATURE<br>Thomas J. [Signature]  |  |



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 4 1 8 2

1. FOR  
STATE  
REGISTRAR

REG. NO.

|   |  |   |  |  |   |
|---|--|---|--|--|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <i>Margaret A Szerbicki</i>   |  |   | 2a. DATE OF DEATH<br>MONTH <i>2</i> DAY <i>9</i> YEAR <i>82</i>                      |  | 2b. HOUR<br><i>4:30</i> M   |
| 3. SEX<br><i>Female</i>   | 4. RACE<br><i>Caucasian</i>  | 5. DATE OF BIRTH<br>MONTH <i>1</i> DAY <i>2</i> YEAR <i>06</i>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><i>76</i> YRS.                                    |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><i>Maryland</i>  | 7b. CITIZEN OF WHAT COUNTRY?<br><i>USA</i>   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><i>Baltimore City</i> MD.                    |   |
| 10. CITY OR TOWN OF DEATH<br><i>Baltimore</i>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><i>University of Maryland</i> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><i>Housewife</i> |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><i>At Home</i>   |
| 13a. STATE<br><i>Maryland</i>   |  |   | 13b. COUNTY<br><i>Balt. City</i>   | 13c. CITY OR TOWN<br><i>Baltimore</i>  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 14. FATHER'S NAME<br>FIRST <i>John</i> MIDDLE <i>O'Malley</i> LAST <i>O'Malley</i>  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST <i>May</i> MIDDLE <i>Christie</i> LAST <i>Neal</i> |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><i>Unknown</i>  |  | 16b. SOCIAL SECURITY NO.<br><i>216-12-9594</i>  |  | 17. INFORMANT<br><i>Hospital Records</i>   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Intracranial Hemorrhage</i><br><i>3989</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <i>Coagulopathy</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause lost.   |  |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><i>2 days</i><br><i>3 days</i>                  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:<br><i>Rheumatic Heart Disease, Congestive Heart Failure, Renal Failure, Gastrointestinal Hemorrhage</i>  |  |   |  |  |   |
| 19a. DATE OF OPERATION<br><i>1/5/82</i>   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><i>Rheumatic Heart Disease Heart Failure</i>  |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  |   |  |  |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. <i>19</i>   |  | 21c. HOW INJURY OCCURRED<br>(ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)    |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |   |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <i>12/26</i> , 19 <i>81</i> , to <i>2/9</i> , 19 <i>82</i> , that <input checked="" type="checkbox"/> (we) lost<br>saw the deceased alive on <i>2/9</i> , 19 <i>82</i> , and that in (my) <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated<br>above, (I) <input checked="" type="checkbox"/> (we) <input type="checkbox"/> (did) <input type="checkbox"/> (did not) view the body after death. |  |   |  |  |   |
| 22b. SIGNATURE<br><i>Francis T. Ferraro, MD</i>   |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> HOUSE STAFF PHYSICIAN <input checked="" type="checkbox"/>  |  | 22c. DATE SIGNED<br><i>2/9/82</i>  |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><i>FRANCIS T. FERRARO, MD</i>  |  | 22e. ADDRESS<br><i>Univ. of Md. Hospital, Balt., Md. 21201</i>  |  |  |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><i>BURIAL</i>   |  | 23b. DATE<br><i>2/12/82</i>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><i>David Ridge</i>                             |   |
| 23d. LOCATION<br>CITY OR TOWN<br><i>PALTO</i>   |  | COUNTY<br><i>Balt.</i>  |  | STATE<br><i>Md.</i>  |   |
| 24. FUNERAL DIRECTOR<br>NAME<br><i>EVANS FUNERAL CHAPLAIN</i>   |  | ADDRESS<br><i>8800 Howard Rd</i>  |  | 25a. DATE REC'D. BY REGISTRAR<br><i>FEB 16 1982</i>                                  |   |
| 25b. REGISTRAR'S NAME<br><i>Charles J. Nathan</i>   |  |   |  |  |   |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified.



CRIMINAL

Hospital Records



From: [illegible]  
To: [illegible]  
Date: [illegible]  
[illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed in the registrar's office with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| STATE OF MARYLAND  |  |   |  |   |  |  |  |                                  |  |   |                                   |
|--|--|---|--|---|--|--|--|----------------------------------|--|---|-----------------------------------|
| DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |   |  |   |  |  |  |                                  |  |   |                                   |
| CERTIFICATE OF DEATH   |  |   |  |   |  |  |  |                                  |  |   |                                   |
| 1. FOR STATE REGISTRAR   |  | REG. NO.  |  |   |  |  |  |                                  |  |   |                                   |
| 1. DECEASED NAME (TYPE OR PRINT)   |  | FIRST   |  | MIDDLE  |  | LAST   |  | 2a. DATE OF DEATH MONTH DAY YEAR |  | 2b. HOUR  |                                   |
| DOY  |  | D   |  | SEABOLT   |  | SR   |  | 2 3 82                           |  | 5:25 am   |                                   |
| 3 SEX  |  | 4 RACE  |  | 5 DATE OF BIRTH MONTH DAY YEAR  |  | 6 AGE (IN YEARS LAST BIRTHDAY)   |  | IF UNDER 1 YEAR MONTHS DAYS      |  | IF UNDER 24 HRS. HOURS MIN.                                   |                                   |
| M  |  | W   |  | 11/14/19  |  | 62 YRS.  |  |                                  |  |   |                                   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY?  |  | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH   |  |                                  |  |   |                                   |
| W. VA  |  | USA   |  |   |  | BALTO. CITY MD.  |  |                                  |  |   |                                   |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |   |  |  |  |                                  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | 12b. KIND OF BUSINESS OR INDUSTRY |
| BALTO  |  | BALTO. CITY HOSP  |  |   |  |  |  |                                  |  | BOILERMAKER   |                                   |
| 13a. STATE   |  | 13b. COUNTY   |  | 13c. CITY OR TOWN   |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS              |  |   |                                   |
| MD.  |  | BALTO   |  | ESSEX   |  |  |  | 317 MARGARET AVE                 |  |   |                                   |
| 14. FATHER'S NAME FIRST MIDDLE LAST  |  |   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST  |  |  |  |                                  |  |   |                                   |
| A. B.  |  |   |  | UNK   |  |  |  | UNK                              |  |   |                                   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)  |  | 16b. SOCIAL SECURITY NO.  |  | 17 INFORMANT  |  | ADDRESS  |  |                                  |  |   |                                   |
| YES  |  | MM II   |  | 232 22 5957   |  | MARY SEABOLT   |  | ABOVE                            |  |   |                                   |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>INTRACEREBRAL HEMORRHAGE</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>4310</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) <u></u> DUE TO, OR AS A CONSEQUENCE OF             |  |   |  |   |  |  |  |                                  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>10 DAYS       |                                   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>HYPERTENSION</u>  |  |   |  |   |  |  |  |                                  |  |   |                                   |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?                               |  |                                  |  |   |                                   |
| 1/23/82  |  | INTRACEREBRAL HEMORRHAGE  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | YES <input type="checkbox"/> NO <input type="checkbox"/>                                     |  |                                  |  |   |                                   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART I OR PART 2)  |  |  |  |                                  |  |   |                                   |
|  |  | P.M. 19   |  |   |  |  |  |                                  |  |   |                                   |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  | 21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE, FARM, ETC.)                                    |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |  |  |                                  |  |   |                                   |
|  |  |   |  |   |  |  |  |                                  |  |   |                                   |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>1/19</u> , 19 <u>82</u> to <u>2/3</u> , 19 <u>82</u> that (I) (we) last saw the deceased alive on <u>2/3</u> , 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |  |   |  |   |  |  |  |                                  |  |   |                                   |
| 22b. SIGNATURE   |  | DEGREE  |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>              |  | 22c. DATE SIGNED   |  |                                  |  |   |                                   |
| <u>R North</u>   |  | MD  |  |   |  | 2/3/82   |  |                                  |  |   |                                   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  | 22e. ADDRESS  |  |   |  |  |  |                                  |  |   |                                   |
| R NORTH  |  | BALTIMORE CITY HOSP.  |  |   |  |  |  |                                  |  |   |                                   |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  | 23b. DATE   |  | 23c. NAME OF CEMETERY OR CREMATORY  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE  |  |                                  |  |   |                                   |
| BURIAL   |  | 2/6/82  |  | GARDENS OF FAITH  |  | BALTO. MD.   |  |                                  |  |   |                                   |
| 24. FUNERAL DIRECTOR NAME  |  |   |  | ADDRESS   |  | 25a. DATE REC'D. BY REGISTRAR  |  | 25b. REGISTRAR'S SIGNATURE       |  |   |                                   |
| J. G. CONNELLY   |  |   |  | 300 MACE  |  | FEB 9 1982   |  | <u>James Van Nuthan</u>          |  |   |                                   |

RECEIVED

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

|  |  |   |   |   |
|--|--|---|---|---|
| 1. FOR<br>STATE<br>REGISTRAR   |  | 2. DATE KNOWN<br>OF ESTI.<br>DEATH MATED <input checked="" type="checkbox"/> MONTH DAY YEAR   |   | 2b. HOUR  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  | FIRST MIDDLE LAST   |   | 2b. HOUR  |
| Richard C. Seabrease Sr.   |  |   |   | M   |
| 3. SEX   | 4. RACE  | 5. DATE OF BIRTH<br>MONTH DAY YEAR  | 6. AGE (IN YEARS<br>LAST BIRTHDAY)  | 7c. DATE<br>PRONOUNCED<br>DEAD  |
| Male   | White  | 9 01 43   | 38 YRS.   | 2 23 19 82  |
| 7a. BIRTHPLACE (STATE OR<br>FOREIGN COUNTRY)   | 7b. CITIZEN OF WHAT COUNTRY?   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH  |   |
| Md.  | U.S.A.   |   |   | Baltimore City, MD.   |
| 10. CITY OR TOWN OF DEATH  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | 12a. USUAL OCCUPATION (TYPE OF WORK<br>FOR MOST OF WORKING LIFE)  | 12b. KIND OF BUSINESS<br>OR INDUSTRY  |   |
| Baltimore  | 2728 Huntington Avenue   | RIGGER  | Md. Drydock   |   |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  | 13a. CITY OR TOWN   | 13b. INSIDE CITY LIMITS?  | 13c. STREET ADDRESS   |
| 13a. STATE   |  | BALTO.  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>           | 2728 Huntington Ave.  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST   |   |   |
| CLARENCE SEABREASE   |  | THELMA E. Hoffmaster  |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)   |  | 16b. SOCIAL SECURITY NO.  | 17. INFORMANT<br>ADDRESS  |   |
| No   |  | 215-40-9265   | Mrs Lois M. NAIL 53 MARICE CIR.   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Arteriosclerotic Cardiovascular Disease</u><br>4292<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.  |  |   |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH                                     |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).  |  |   |   |   |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |   | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR<br>CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME,<br>STREET, FACTORY, FARM, ETC.)  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                             |   |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |  |   |   |   |
| ACTUAL<br>SIGNATURE <u>Virginia L. Dolan</u>   |  | TITLE (SPECIFY)<br>M.D. Assistant MEDICAL EXAMINER  |   | DATE<br>SIGNED 2-24-82  |
| EXAMINER'S NAME<br>(TYPE OR PRINT) Virginia L. Dolan, M.D.   |  | ADDRESS 111 Penn Street   |   |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)   | 23b. DATE  | 23c. NAME OF CEMETERY OR CREMATORY  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE                                    |   |
| BURIAL   | FEB 27, 1982   | PARKWOOD Cem.   | BALTIMORE MD.   |   |
| 24. FUNERAL DIRECTOR<br>NAME   |  | 25a. DATE REC'D. BY REGISTRAR   | 25b. REGISTRAR'S SIGNATURE  |   |
| HARTLEY Miller   |  | 7527 Harford Rd   | FEB 25 1982   |   |

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BALTO

MD

CLARENCE

GEORGE E. HOFF

No

215 40 415 Mr. Lois M. Hall 33 MARICE CIR

RIVER

2158 Washington Ave

BURIAL FEBRUARY 1942 PARKWOOD CEM

DATE OF BIRTH 1900

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  |  | REG. NO. 8 2 0 4 1 8 5  |  |
|---|--|--|--|--|---|--|
| 1. FOR STATE REGISTRAR  |  |  | 1. DECEASED NAME (TYPE OR PRINT)   |  | 2a. DATE OF DEATH   |  |
|   |  |  | FIRST MIDDLE LAST<br>ANNA SEMIATIN   |  | MONTH DAY YEAR<br>2 24 82   |  |
| 3. SEX<br>FEMALE  |  |  | 4. RACE<br>White   |  | 5. DATE OF BIRTH  |  |
|   |  |  | MONTH DAY YEAR<br>9 26 00  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>81   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>RUSSIA   |  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE  |  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>SINAI HOSPITAL |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.  |  |
| 12. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>MARYLAND   |  |  | 13b. COUNTY<br>BALTIMORE   |  | 13c. CITY OR TOWN<br>BALTIMORE  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>NATHAN FISHMAN  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>UNKNOWN   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>AT HOME  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>NO   |  |  | 16b. SOCIAL SECURITY NO.<br>214-12-1692  |  | 17. INFORMANT<br>MORRIS SEMIATIN<br>3910 GANNON RD., WHEATON, MD 20902  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Staphylococcus Septicemia</u><br>DUE TO, OR AS A CONSEQUENCE OF (b) <u>Respiratory Failure.</u><br>DUE TO, OR AS A CONSEQUENCE OF (c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |  |  |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) _____   |  |  |  |  |   |  |
| 19a. DATE OF OPERATION  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  |  |  |  |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>1-25</u> , 19 <u>82</u> , to <u>2-24</u> , 19 <u>82</u> , that (I) (we) last saw the deceased alive on <u>2-24</u> , 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                |  |  |  |  |   |  |
| 22b. SIGNATURE<br>Elio Raul Novoa   |  |  | DEGREE   |  | 22c. DATE SIGNED<br>2-24-82   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Elio Raul Novoa  |  |  | 22e. ADDRESS<br>SINAI HOSP. - BALTO., MD   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>BURIAL   |  |  | 23b. DATE<br>FEB. 25, 1982   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>FORBAND   |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>ROSEDALE BALTO. MD  |  |  | 24. FUNERAL DIRECTOR<br>SOL LEVINSON & BROS., INC.<br>6010 REISTERSTOWN RD. BALTO., MD 21215                             |  |   |  |
| 25a. DATE REC'D. BY REGISTRAR   |  |  | 25b. REGISTRAR'S SIGNATURE<br>MAR 4 1982 Frances Jan Nathan  |  |   |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and item 18 completed.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |                      |   |   |   |  |   |  |  |
|---|--|--|----------------------|---|---|---|--|---|--|--|
| 1. FOR STATE REGISTRAR  |  |  |                      |   | REG. NO.  |   |  |   |  |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br>FREDERICK JOHN SENDELBACH   |  |  |                      |   | 2a. DATE OF DEATH MONTH DAY YEAR<br>02 20 82  |   |  |   |  |  |
| 3. SEX<br>Male  |  | 4. RACE<br>White   |                      | 5. DATE OF BIRTH MONTH DAY YEAR<br>4 5 99   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>82 YRS.                              |  | 7b. HOUR<br>2:05 PM   |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |                      | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.              |  |   |  |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>St. Agnes Hospital |                      |   |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Broker |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Aetna Life & Cas.                            |  |  |
| 13a. STATE<br>Maryland  |  |  |                      |   | 13b. COUNTY<br>Howard   |   | 13c. CITY OR TOWN<br>Ellicott City   |   | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>John Sendebach   |  |  |                      |   | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Katherine Freiman   |   |  |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>NO   |  |  |                      |   | 16b. SOCIAL SECURITY NO.<br>218-01-9166   |   | 17. INFORMANT ADDRESS<br>Anita B. Sendebach 3370 L. North Chatham Rd. 21043    |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Coronary arrest</u><br>DUE TO, OR AS A CONSEQUENCE OF (b) <u>renal failure / uremia</u><br>DUE TO, OR AS A CONSEQUENCE OF (c) <u>metastatic colonic carcinoma</u><br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a. |  |  |                      |   |   |   |  |   |  |  |
| 19a. DATE OF OPERATION  |  |  |                      |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)   |  |  |                      |   | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2) |   |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |  |                      |   | 21e. PLACE OF INJURY (AT HOME STREET FACTORY, OFFICE, FARM, ETC.)   |   | 21f. LOCATION CITY OR TOWN COUNTY STATE  |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>1/28/80</u> , 19 <u>80</u> , to <u>2/20/82</u> , 19 <u>82</u> , that (I) (we) last saw the deceased alive on <u>2/20</u> , 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.  |  |  |                      |   |   |   |  |   |  |  |
| 22b. SIGNATURE<br>Jerry D. Skarbek M.D.   |  |  |                      |   | DEGREE<br>PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |   |  | 22c. DATE SIGNED<br>2/20/82   |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Jerry D. Skarbek   |  |  |                      |   | 22e. ADDRESS<br>900 Catons Ave. Baltimore, Md.  |   |  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial   |  |  | 23b. DATE<br>2/23/82 |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Loudon Park Cemetery  |   | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>Baltimore Maryland                  |   |  |  |
| 24. FUNERAL DIRECTOR NAME<br>Hubbard Funeral Home, Inc. 4107 Wilkens Ave.   |  |  |                      |   | 25a. DATE REC'D. BY REGISTRAR<br>FEB 22 1982  |   | 25b. REGISTRAR'S SIGNATURE<br>[Signature]                                      |   |  |  |

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STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

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REG. NO.

|  |  |   |  |   |  |   |   |  |   |   |  |
|--|--|---|--|---|--|---|---|--|---|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>THERESA P SERGI   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>2/25/82                         |   |  | 2b. HOUR<br>1/30 PM   |   |  |   |   |  |
| 3. SEX<br>F  |  | 4. RACE<br>W  |  | 5. DATE OF BIRTH<br>Sept 17/07  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>74   |   | 7. IF UNDER 1 YEAR<br>MONTHS DAYS                        |   | 8. IF UNDER 24 HRS.<br>HOURS MIN.               |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN)<br>New York  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>City                                  |   |  |   |   |  |
| 10. CITY OR TOWN OF DEATH<br>Balto.  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>306 S. Exeter st |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Housewife |   | 12b. KIND OF BUSINESS OR INDUSTRY<br>Res.                |   |   |  |
| 13a. STATE<br>Md.  |  |   | 13b. COUNTY<br>Balto.  |   | 13c. CITY OR TOWN<br>Balto.  |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br>344 Albemarle St   |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Edward sala  |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Concetta Geraci  |  |   |   |  |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>N.   |  |   |  | 16b. SOCIAL SECURITY NO.<br>217/32/7513   |  | 17. INFORMANT<br>Benjamin Sergi 344 Albemarle St                              |   |  |   |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Congestive Heart Failure<br>4292<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) Arteriosclerotic Cardiovascular disease<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)             |  |   |  |   |  |   |   |  |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |   |  |   |  |   |   |  |   |   |  |
| Hypertension; Diabetes Mellitus  |  |   |  |   |  |   |   |  |   |   |  |
| 19a. DATE OF OPERATION   |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |   |   |  |   |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |   |   |  |   |   |  |
| 22a. I certify that (I) (the hospital) attended the deceased from 1973, 19, to 1982, that (I) (we) lost<br>saw the deceased alive on 1982, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above. (I) (we) (did) (did not) view the body after death. |  |   |  |   |  |   |   |  |   |   |  |
| 22b. SIGNATURE<br>Salvatore R. Donohue   |  |   |  |   |  |   |   |  |   | 22c. DATE SIGNED                                |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>SALVATORE R. DONOHUE  |  |   |  |   |  |   |   |  |   | 22e. ADDRESS<br>827 LINDEN AVE.                 |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial   |  |   | 23b. DATE<br>3/1/82  |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Holy Redeemer                            |   |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>BALTO. Md. |   | 23e. DATE REC'D. BY REGISTRAR<br>MAR 1 1982     |  |
| 24. FUNERAL DIRECTOR<br>DEAN NOCE & SONS 322 S. HIGH ST. 21202   |  |   |  |   |  |   |   |  |   |   |  |
| 25a. DATE REC'D. BY REGISTRAR<br>MAR 1 1982  |  |   |  |   |  |   |   |  |   |   |  |
| 25b. REGISTRAR'S SIGNATURE<br>Ramon J. [Signature]   |  |   |  |   |  |   |   |  |   |   |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the funeral director after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be contacted.



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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

|  |  |                  |               |   |  |  |  |   |                 |   |  |   |                    |   |                    |  |  |
|--|--|------------------|---------------|---|--|--|--|---|-----------------|---|--|---|--------------------|---|--------------------|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  |                  | FIRST<br>MARK |   |  | MIDDLE<br>A.   |  |   | LAST<br>SHAFFER |   |  | 2a. DATE KNOWN<br>OF DEATH<br>ESTIMATED<br><input checked="" type="checkbox"/> MONTH DAY YEAR<br><input type="checkbox"/> 2-12-82 <sub>19</sub> |                    |   | 2b. HOUR<br>M<br>A |  |  |
| 3. SEX<br>male   |  | 4. RACE<br>white |               | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>Nov 14, 1960  |  | 6. AGE (IN YEARS<br>LAST BIRTHDAY)<br>21 YRS.                        |  | IF UNDER 24 YR.<br>MONTHS DAYS HOURS MIN  |                 | 7c. DATE<br>PRONOUNCED<br>DEAD<br>2-12-82 <sub>19</sub>                     |  |   | 7d. HOUR<br>M<br>A |   |                    |  |  |
| 7b. BIRTHPLACE (STATE OR<br>FOREIGN COUNTRY)<br>Baltimore, Md.   |  |                  |               | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  |  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                 |   |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City  |                    |   |                    |  |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore   |  |                  |               | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Between Ostend & Sharp Sts. |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK<br>FOR MOST OF WORKING LIFE)<br>Mechanic - Md. Cup Corp.  |                 |   |  | 12b. KIND OF BUSINESS<br>OR INDUSTRY  |                    |   |                    |  |  |
| 13a. STATE<br>Maryland   |  |                  |               | 13b. COUNTY<br>--   |  | 13c. CITY OR TOWN<br>Baltimore                                       |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |                 | 13e. STREET ADDRESS<br>3137 Keswick Road (21211)                            |  |   |                    |   |                    |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Gilbert P. Shaffer   |  |                  |               |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Shirley E. Tritapoe |  |   |                 |   |  |   |                    |   |                    |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br>No  |  |                  |               | (IF YES, GIVE WAR OR DATES)<br>-- --  |  | 16b. SOCIAL SECURITY NO.<br>220-84-8211                              |  | 17. INFORMANT<br>ADDRESS<br>Mr. Gilbert Shaffer- 3137 Keswick Road  |                 |   |  |   |                    |   |                    |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Blunt force injuries to head and stabwounds of<br>9660 chest<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.<br>(b) DUE TO, OR AS A CONSEQUENCE OF<br>(c)   |  |                  |               |   |  |  |  |   |                 |   |  |   |                    | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |                    |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 is:   |  |                  |               |   |  |  |  |   |                 |   |  |   |                    |   |                    |  |  |
| 19a. DATE OF OPERATION   |  |                  |               | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  |  |  |   |                 |   |  | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |                    |   |                    |  |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input checked="" type="checkbox"/> OR<br>CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |  |                  |               | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 2-12-82 <sub>19</sub>   |  |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)<br>subject found with injuries to head and chest                              |                 |   |  |   |                    |   |                    |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/><br>AT WORK AT WORK  |  |                  |               | 21e. PLACE OF INJURY (AT HOME,<br>STREET, FACTORY, FARM, ETC.)<br>street (betw)   |  |  |  | 21f. LOCATION<br>CITY OR TOWN STATE<br>Baltimore, Maryland  |                 |   |  |   |                    |   |                    |  |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input checked="" type="checkbox"/> , Undetermined manner <input type="checkbox"/> . |  |                  |               |   |  |  |  |   |                 |   |  |   |                    |   |                    |  |  |
| ACTUAL<br>SIGNATURE<br>Margarita A. Koroll, M.D.   |  |                  |               | TITLE (SPECIFY)<br>M.D. Assistant   |  |  |  | MEDICAL EXAMINER  |                 |   |  | DATE<br>SIGNED 2-13-82  |                    |   |                    |  |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)<br>Margarita A. Koroll, M.D.  |  |                  |               | ADDRESS 111 Penn Street   |  |  |  |   |                 |   |  |   |                    |   |                    |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial   |  |                  |               | 23b. DATE<br>Feb 16, 1982   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Good Shepherd Cemetery         |  |   |                 | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Ellicott City, Howard Co, Md. |  |   |                    |   |                    |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>A. Alan Seitz Funeral Home   |  |                  |               | ADDRESS<br>3818 Roland Ave.   |  |  |  | 25a. DATE<br>FEB 17 1982  |                 |   |  | 25b. REGISTRAR'S SIGNATURE<br>Thane Jan   |                    |   |                    |  |  |



## CERTIFICATE OF DEATH

REG. NO.

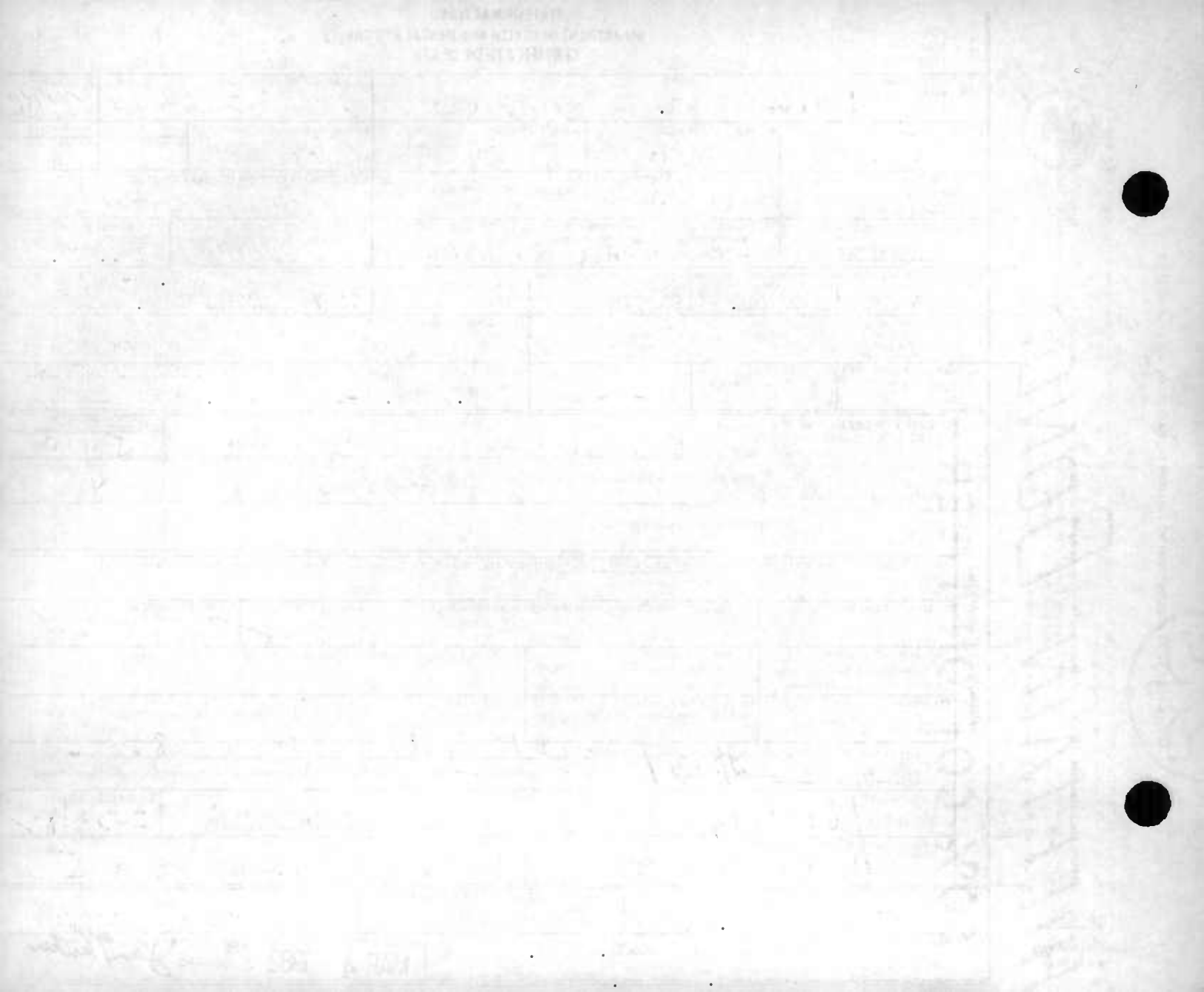
1- FOR  
STATE  
REGISTRAR

|  |  |  |   |  |  |  |  |   |  |  |  |
|--|--|--|---|--|--|--|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>NAMI R. SHAPIRO</b>   |  |  | 2a. DATE OF DEATH<br>MONTH <b>2</b> DAY <b>23</b> YEAR <b>82</b>      |  |  | 2b. HOUR<br><b>7:15 PM</b>   |  |   |  |  |  |
| 3. SEX<br><b>FEMALE</b>  |  | 4. RACE<br><b>WHITE</b>  |   | 5. DATE OF BIRTH<br>MONTH <b>12</b> DAY <b>29</b> YEAR <b>17</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>64</b> YRS.  |  | 7. IF UNDER 1 YEAR<br>MONTHS <b>0</b> DAYS <b>0</b>   |  | 7. IF UNDER 24 HRS<br>HOURS <b>0</b> MIN. <b>0</b> |  |
| 8. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MARYLAND</b>  |  | 9. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |   | 10. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 11. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTO CITY</b> MD.   |  |   |  |  |  |
| 12. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>  |  | 13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>LEWINDALE CENTER</b> |   |  |  | 14. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>SECRETARY</b>  |  | 15. KIND OF BUSINESS OR INDUSTRY<br><b>INS. CO.</b>   |  |  |  |
| 16. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>16a. STATE <b>MARYLAND</b> 16b. COUNTY <b>BALTO.</b> 16c. CITY OR TOWN <b>BALTIMORE</b>   |  |  |   |  |  | 17. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 18. STREET ADDRESS<br><b>APT. B-2<br/>7207 CHALKSTONE DR. 21208</b>   |  |  |  |
| 19. FATHER'S NAME<br>FIRST <b>JACOB</b> MIDDLE <b>REAMER</b> LAST <b>BERKOW</b>  |  |  | 20. MOTHER'S MAIDEN NAME<br>FIRST <b>DORA</b> MIDDLE <b>BERKOW</b>    |  |  |  |  |   |  |  |  |
| 21. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>NO</b>  |  |  | 22. SOCIAL SECURITY NO.<br><b>213-01-9454</b>                         |  |  | 23. INFORMANT <b>AARON SHAPIRO</b> ADDRESS <b>7207 CHALKSTONE DR., APT. B-2 BALTO., MD 21208</b>   |  |   |  |  |  |
| 24. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Breast Cancer - metastasis</b><br>1749<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. }<br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>including Bone &amp; Brain</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>Syn</b><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1749</b> |  |  |   |  |  |  |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |  |   |  |  |  |  |   |  |  |  |
| 25. DATE OF OPERATION  |  |  | 26. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  |  | 27. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 28. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |  |
| 29. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  | 30. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. <b>19</b>      |  |  | 31. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)  |  |   |  |  |  |
| 32. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  |  | 33. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  |  | 34. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |  |  |
| 35. I certify that (I) (this hospital) attended the deceased from <b>12/31/81</b> to <b>2/23/82</b> , that (we) lost saw the deceased alive on <b>2/23/82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, that (we) (did) (did not) view the body after death.  |  |  |   |  |  |  |  |   |  |  |  |
| 36. SIGNATURE<br><b>Noel D. List</b>   |  |  |   |  |  | 37. DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 38. DATE SIGNED<br><b>2/23/82</b>   |  |  |  |
| 39. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>NOEL D. LIST</b>  |  |  | 40. ADDRESS<br><b>LEWINDALE CENTER 21215</b>                          |  |  |  |  |   |  |  |  |
| 41. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>BURIAL</b>  |  |  | 42. DATE<br><b>FEB. 24, 1982</b>                                      |  | 43. NAME OF CEMETERY OR CREMATORY<br><b>AITZ CHAIM</b> |  |  | 44. LOCATION<br>CITY OR TOWN <b>BALTIMORE</b> COUNTY <b>MARYLAND</b> STATE <b>MARYLAND</b>                                |  |  |  |
| 45. FUNERAL DIRECTOR<br>NAME <b>SOL LEVINSON &amp; BROS., INC.</b><br><b>6010 REISTERSTOWN RD. BALTO., MD 21215</b>  |  |  |   |  |  | 46. DATE REC'D. BY REGISTRAR<br><b>MAR 4 1982</b><br>REGISTRAR'S SIGNATURE <b>James J. Nathan</b>  |  |   |  |  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Papers must be retained by the hospital or attending physician.

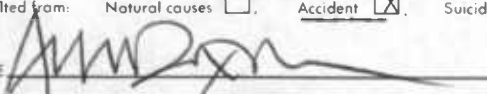

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 3 FOR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITH PAGES 3 AND 4 AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH   |                         |   |  |   |                  |   |  |   |  | REG. NO. 04190                               |  |
|---|-------------------------|---|--|---|------------------|---|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>LESLIE C. SHAW</b>   |                         |   |  |   |                  | 2a. DATE KNOWN OF DEATH<br>ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR <b>2 25 1982</b>            |  | 2b. HOUR <b>3:40</b>  |  |  |  |
| 3. SEX<br><b>male</b>   | 4. RACE<br><b>white</b> | 5. DATE OF BIRTH<br>MONTH DAY YEAR <b>3/14/1901</b>   | 6. AGE (IN YEARS)<br>LAST BIRTHDAY MONTH DAY YEAR <b>80</b> YRS. | IF UNDER 1 YR.<br>MONTHS DAYS HOURS MIN.  | IF UNDER 24 HRS. | 7c. DATE PRONOUNCED DEAD<br>MONTH DAY YEAR <b>2 25 1982</b>   |  | 7d. HOUR <b>3:40</b>  |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>  |                         | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b>   |  |   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   |                         | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Sinai Hospital</b> |  |   |                  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Statistician-Ret.</b>                           |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Newspaper</b>                               |  |  |  |
| 13a. STATE<br><b>Maryland</b>   |                         |   |  |   |                  | 13b. CITY OR TOWN<br><b>Baltimore</b>   |  | 13c. STREET ADDRESS<br><b>Woodlawn</b>  |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Wilbur Shaw</b>  |                         |   |  |   |                  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Mamie Louise Unknown</b>  |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br><b>No</b>  |                         | 16b. SOCIAL SECURITY NO.<br><b>212-01-7138</b>  |  | 17. INFORMANT ADDRESS<br><b>1-Lambdin L. Shaw, 6829 Dogwood Road</b>  |                  |   |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Fracture of cervical spine with brainstem injury</b><br>9179<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last:<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). |                         |   |  |   |                  |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| 19a. DATE OF OPERATION  |                         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  |   |                  |   |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |                         | 21b. TIME OF INJURY<br>HOUR <del>XX</del> MONTH DAY YEAR<br><b>3:45 P.M. 2-18- 1982</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)<br><b>Pedestrian struck by car trunk hood.</b>                                |                  |   |  |   |  |  |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>   |                         | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)<br><b>driveway</b>  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br><b>6831 Dogwood Rd. Balto. Md.</b>   |                  |   |  |   |  |  |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .  |                         |   |  |   |                  |   |  |   |  |  |  |
| ACTUAL SIGNATURE<br>   |                         | TITLE (SPECIFY)<br>M.D. <b>Assistant</b> MEDICAL EXAMINER   |  |   |                  | DATE SIGNED <b>2-25-82</b>  |  |   |  |  |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)<br><b>Ann M. Dixon, M.D.</b>   |                         | ADDRESS<br><b>111 Penn St.</b>  |  |   |                  |   |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |                         | 23b. DATE<br><b>3/1/82</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Woodlawn Cemetery</b>  |                  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Woodlawn, Baltimore Co., Md.</b>                                   |  |   |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Della Mae Thomas</b>   |                         | ADDRESS<br><b>6411 Windsor Mill Rd</b>  |  | 25a. RECEIVED BY REGISTRAR<br><b>MAR 8 1982</b>   |                  | 25b. REGISTRAR'S SIGNATURE<br> |  |   |  |  |  |

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Item 6 g566 4/21/82 gj

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 4 1 9 1

REG. NO.

|   |  |  |   |   |  |  |  |  |                                   |   |  |   |  |
|---|--|--|---|---|--|--|--|--|-----------------------------------|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Lewis Sheard</b>                        |  |  | 2a. DATE OF DEATH<br>MONTH <b>2</b> DAY <b>2</b> YEAR <b>82</b> |   |  | 2b. HOUR<br><b>1155 AM</b>   |  |  |                                   |   |  |   |  |
| 3. SEX<br><b>Male</b>   |  | 4. RACE<br><b>Black</b>  |   | 5. DATE OF BIRTH<br>MONTH <b>3</b> DAY <b>2</b> YEAR <b>91</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>89</b> YRS. MONTHS <b>90</b>                   |  | IF UNDER 1 YEAR<br>MONTHS <b>90</b> DAYS <b>90</b> |                                   | IF UNDER 24 HRS.<br>HOURS <b>90</b> MIN.  |  |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>S.C.</b>                          |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.                    |  |  |                                   |   |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>                                     |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Johns Hopkins Hospital</b> |   |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)                     |  |  | 12b. KIND OF BUSINESS OR INDUSTRY |   |  |   |  |
| 13a. STATE<br><b>MD</b>   |  |  |   |   |  | 13b. COUNTY  |  | 13c. CITY OR TOWN<br><b>Baltimore</b>              |                                   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>2512 E. Federal St.</b> |  |
| 14. FATHER'S NAME<br>FIRST <b>William</b> MIDDLE <b>Sheard</b> LAST <b>Annie</b>  |  |  |   |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>Annie</b> MIDDLE <b>Annie</b> LAST <b>Annie</b> |  |  |                                   |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b> |  |  |   | 16b. SOCIAL SECURITY NO.<br><b>247-30-6097</b>  |  | 17. INFORMANT ADDRESS<br><b>Sarah A. Fleming 2512 E. Federal St.</b>                 |  |  |                                   |   |  |   |  |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) **hypotension**APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH**3 days****4380**

DUE TO, OR AS A CONSEQUENCE OF

(b) **sepsis****3 days**

DUE TO, OR AS A CONSEQUENCE OF

(c) **multiple cerebrovascular accidents****years**

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)

**N/A**

|  |  |  |  |   |  |  |  |
|--|--|--|--|---|--|--|--|
| 19a. DATE OF OPERATION<br><b>N/A</b>   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>N/A</b>                       |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>          |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING TO CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)<br><b>N/A</b>   |  | 21b. TIME OF INJURY<br>HOUR A.M. <b>PM</b> DAY <b>19</b> YEAR <b>82</b>              |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)<br><b>N/A</b>  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/><br><b>N/A</b>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)<br><b>N/A</b> |  | 21f. LOCATION<br>STREET <b>N/A</b> CITY OR TOWN <b>N/A</b> COUNTY <b>N/A</b> STATE <b>N/A</b> |  |  |  |
| 22a. I certify that (I) (his hospital) attended the deceased from <b>JAN 27</b> , 19 <b>82</b> , to <b>FEB 2</b> , 19 <b>82</b> , that (I/we) saw the deceased alive on <b>FEB 2</b> , 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I/we) (did) (did not) view the body after death. |  |  |  |   |  |  |  |
| 22b. SIGNATURE<br><b>Lawrence E. Widman, MD</b>  |  |  |  | DEGREE<br><b>MD</b>   |  | 22c. DATE SIGNED<br><b>FEB 2, 1982</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>LAWRENCE E. WIDMAN</b>   |  |  |  | 22e. ADDRESS<br><b>JOHN'S HOPKINS HOSPITAL, BALTIMORE</b>                                     |  |  |  |

|   |  |                            |  |  |  |  |  |
|---|--|----------------------------|--|--|--|--|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b> |  | 23b. DATE<br><b>2/6/82</b> |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Church Cem.</b> |  | 23d. LOCATION<br>CITY OR TOWN <b>Hodges</b> COUNTY <b>S.C.</b> |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Wm. C. March F/H</b>       |  |                            |  | ADDRESS<br><b>1101 E. North Ave.</b>                     |  | 25a. DATE REC'D BY REGISTRAR<br><b>FEB 3 1982</b>              |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The death certificate must be signed by the attending physician and completed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial-transit permit. Then please remove carbon #2 and #3 and return them to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

APR 25 1954

RECEIVED

MAIL

MAIL ROOM

MAIL ROOM



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers, pages 1 and 2 should be filed in the office after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

1- FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 4 1 9 2

REG. NO.

|  |  |  |   |  |  |
|--|--|--|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Dorothy (Dowdy) Sherden (Sheroden)</b>   |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>2 11 / 82</b>   |  | 2b. HOUR<br><b>2:49 PM</b>   |
| 3 SEX<br><b>Female</b>   | 4 RACE<br><b>Black</b>   | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br><b>10 9 22</b>  | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>59</b>   | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.<br><b>YRS.</b>                       |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>N.C.</b>   | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.                                |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Baltimore City Hosp.</b> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)                                |  | 12b. KIND OF BUSINESS OR INDUSTRY  |
| 13a. STATE<br><b>MD</b>  |  | 13b. COUNTY<br><b>Baltimore</b>  | 13c. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS<br><b>725 N. Lakewood Ave.</b>                             |  |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Samuel Woods</b>   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Janie Hayes</b>  |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>No</b>  |  | 16b. SOCIAL SECURITY NO<br><b>N/A</b>  |   | 17 INFORMANT<br><b>Brenda Woods 818 Belnord Ave.</b>                           |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiopulmonary Arrest</b><br><b>4100</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>ALT</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) |  |  |   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)<br><b>COPD</b>  |  |  |   |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>      | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>2/10</b> , 19 <b>82</b> , to <b>2/17</b> , 19 <b>82</b> , that (I) (we) lost<br>saw the deceased alive on <b>2/17</b> , 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.   |  |  |   |  |  |
| 22b. SIGNATURE<br><b>Bram Zucker</b>   |  | DEGREE<br><b>MD</b>  |   | 22c. DATE SIGNED<br><b>2/18/82</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Bram Zucker</b>  |  | 22e. ADDRESS<br><b>Baltimore City Hospital</b>   |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  | 23b. DATE<br><b>2/23/82</b>  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Md. Veteran Cem.</b>  |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Crownsville MD</b>            |  |
| 24 FUNERAL DIRECTOR<br>NAME<br><b>Wm. C. March F/H</b>   |  | ADDRESS<br><b>1101 E. North Ave.</b>   |   | 25a. DATE REC'D. BY REGISTRAR<br><b>FEB 19 1982</b>                            |  |
|  |  |  |   | 25b. REGISTRAR'S SIGNATURE<br><b>Frances Jan Nathan</b>                        |  |

1 FEB 10 1980

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  |   |  |   |  |   |                                   | REG. NO.  |  |
|---|--|---|--|---|--|---|--|---|-----------------------------------|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>FRANCES C SHOCK.</b>   |  |   |  |   |  | 2a. DATE OF DEATH<br>MONTH <b>2</b> DAY <b>13</b> YEAR <b>82</b>  |  | 2b. HOUR<br><b>9.11</b> <sup>P</sup>  |                                   |   |  |
| 3. SEX<br><b>Female</b>   |  | 4. RACE<br><b>Cauc.</b>   |  | 5. DATE OF BIRTH<br>MONTH <b>9</b> DAY <b>5</b> YEAR <b>20</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>61</b> YRS.   |  | IF UNDER 1 YEAR<br>MONTHS <b></b> DAYS <b></b>  |                                   | IF UNDER 74 HRS.<br>HOURS <b></b> MIN. <b></b>  |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City,</b> MD.                                      |  |   |                                   |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Sinai Hospital</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Secretary Black &amp; Decker</b> |  |   | 12b. KIND OF BUSINESS OR INDUSTRY |   |  |
| 13a. STATE<br><b>Maryland</b>   |  | 13b. COUNTY<br><b>Baltimore</b>   |  | 13c. CITY OR TOWN<br><b>Owings Mills</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>         |  | 13e. STREET ADDRESS<br><b>210 Murgate Lane</b>  |                                   |   |  |
| 14. FATHER'S NAME<br>FIRST <b>Lawrence</b> MIDDLE <b>M.</b> LAST <b>Caples</b>  |  |   |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>Mary</b> MIDDLE <b>E.</b> LAST <b>Hines</b>                        |  |   |                                   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>No</b>  |  |   |  | 16b. SOCIAL SECURITY NO.<br><b>219-05-4533</b>  |  | 17. INFORMANT<br>ADDRESS<br><b>George Wilhelm 115 W. Seminary Ave.</b>                                  |  |   |                                   |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br><b>4100</b> IMMEDIATE CAUSE (a) <b>Acute Antero Septal Myocardial</b><br>DUE TO, OR AS A CONSEQUENCE OF <b>Infarction!</b><br>(b) <b>C Cardiac shock.</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b></b>      |  |   |  |   |  |   |  |   |                                   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH   |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS <u>CONTRIBUTING TO DEATH</u> BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |   |  |   |  |   |  |   |                                   |   |  |
| 19a. DATE OF OPERATION  |  |   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                                   | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART I OR PART 2)                          |  |   |                                   |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  |   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |                                   |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |  |   |  |   |  |   |                                   |   |  |
| 22b. SIGNATURE<br><b>D. S. PATAL</b>  |  |   |  |   |  | DEGREE<br><b>MD</b>   |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |                                   | 22c. DATE SIGNED<br><b>2/13/82.</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>D. S. PATAL.</b>  |  |   |  |   |  | 22e. ADDRESS<br><b>SINAI HOSPITAL.</b>  |  |   |                                   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |  |   |  | 23b. DATE<br><b>Feb. 17, 1982</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Prospect Hill Cemetery</b>                                     |  | 23d. LOCATION<br>CITY OR TOWN <b>Towson</b> COUNTY <b>Balto.,</b> STATE <b>Maryland</b>   |                                   |   |  |
| 24. FUNERAL DIRECTOR<br>NAME <b>Ruck Towson Funeral Home, Inc.</b> ADDRESS <b>Towson, Md. 21204</b>   |  |   |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>FEB 16 1982</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><i>James J. North</i>   |                                   |   |  |



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |  |                       |  |  |  |  |  |   |                        | REG. NO. 5204194   |  |
|--|--|-----------------------|--|--|--|--|--|---|------------------------|--|--|
| 1. FOR STATE REGISTRAR   |  |                       |  |  |  |  |  |   |                        |  |  |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br>GEORGE SILVEN, JR.   |  |                       |  |  |  |  |  |   |                        | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH DAY YEAR<br>2 18 19 82 |  |
| 3. SEX<br>male   |  | 4. RACE<br>white      |  | 5. DATE OF BIRTH (MONTH DAY YEAR)<br>7/28/14   |  | 6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS HOURS MIN.<br>67 YRS.                            |  | 7c. DATE PRONOUNCED DEAD<br>2 18 19 82  |                        | 2d. HOUR<br>7:31 a   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Michigan  |  |                       |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  |  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                        | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.                               |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore   |  |                       |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>719 S. Broadway |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)   |                        | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, RESIDENCE BEFORE ADMISSION)  |  |                       |  |  |  |  |  |   |                        |  |  |
| 13a. STATE<br>Md.  |  | 13b. COUNTY<br>Balto. |  | 13c. CITY OR TOWN<br>Balto.  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br>306 #. North Ave. East.  |                        |  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>George Silven, Sr.  |  |                       |  |  |  |  |  |   |                        | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Mary Kozlowski                             |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)<br>Yes  |  |                       |  | 16b. SOCIAL SECURITY NO.<br>N.W. 44 500/14/0706  |  | 17. INFORMANT ADDRESS<br>M.J. Olichney 411 Kebey Rd. Grosse Pointe Mich.                     |  |   |                        |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1 DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardiovascular disease</u><br>4292<br>(b) _____<br>(c) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.  |  |                       |  |  |  |  |  |   |                        | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1   |  |                       |  |  |  |  |  |   |                        |  |  |
| 19a. DATE OF OPERATION   |  |                       |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  |  |  |   |                        | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>         |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  |                       |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)                |  |   |                        |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  |                       |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |   |                        |  |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |  |                       |  |  |  |  |  |   |                        |  |  |
| ACTUAL SIGNATURE <u>Ann M. Dixon</u>   |  |                       |  |  |  | TITLE (SPECIFY)<br>M.D. Assistant  |  |   | DATE SIGNED<br>2-18-82 |  |  |
| EXAMINER'S NAME (TYPE OR PRINT)<br>Ann M. Dixon, M.D.  |  |                       |  |  |  | ADDRESS<br>111 Penn St.  |  |   |                        |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial  |  |                       |  | 23b. DATE<br>2/25/82   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Mt. Olivet   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>Grosse Pointe Wayne Co. Mich.  |                        |  |  |
| 24. FUNERAL DIRECTOR NAME<br>Della Noce & Sons 322 S. High St. Balto. Md.  |  |                       |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br>FEB 23 1982   |  | 25b. REGISTRAR'S SIGNATURE<br><u>Anna J. [Signature]</u>  |                        |  |  |





STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 4 1 9 5

FOR  
1 - STATE  
REGISTRAR

REG. NO.

|   |  |   |  |   |  |  |  |
|---|--|---|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>IDA  |  | FIRST MIDDLE LAST<br>SISENWAIR  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>FEB. 25 1982  |  | 2b. HOUR<br>2:15 P.M.  |  |
| 3. SEX<br>FEMALE  |  | 4. RACE<br>CAUCASIAN  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>AUG. 21 1899   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>82 YRS  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>POLAND   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA.  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD  |  |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>LEVINDAVE HEBREW GERIATRIC CENTER + HOSPITAL |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>HOUSEWIFE   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>AT HOME   |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13b. STATE<br>MD  |  | 13c. CITY OR TOWN<br>BALTIMORE  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 13e. STREET ADDRESS<br>2500 W. BELVEDERE AVE. 21215<br>CONCORD APTS. APT. # 704  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>KALMAN   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE<br>EVA GILBERT  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) NO   |  |  |  |
| 16b. SOCIAL SECURITY NO.<br>092-14-6603   |  | 17. INFORMANT ADDRESS<br>MRS. BLOSSOM NACHMAN<br>5806 GIST AVE. BALTO., MD 21215  |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) PANCREATIC CA<br>1579<br>DUE TO, OR AS A CONSEQUENCE OF (b)<br>DUE TO, OR AS A CONSEQUENCE OF (c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>7 MONTHS          |  |   |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)  |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a. I certify that (this hospital) attended the deceased from FEB 12, 19 82, to FEB 25, 19 82, that (we) lost saw the deceased alive on FEB. 25 19 82, and that in (our) opinion death occurred on the date and hour and from the causes stated above. (we) (did) (did not) view the body after death. |  |   |  |   |  |  |  |
| 22b. SIGNATURE<br>E. K. W.  |  | DEGREE  |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>       |  | 22c. DATE SIGNED<br>2/25/82  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>ESTREITA O. KW   |  | 22e. ADDRESS<br>LEVINDAVE HEBREW GERIATRIC CENTER + HOSPITAL  |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>BURIAL   |  | 23b. DATE<br>FEB. 26, 1982  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>MOUNT HEBRON  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>FLUSHING LONG IS. NY   |  |
| 24. FUNERAL DIRECTOR<br>NAME SOL LEVINSON & BROS., INC.<br>6010 REISTERSTOWN RD. BALTO., MD 21215   |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br>MAR 4 1982   |  | 25b. REGISTRAR'S SIGNATURE<br>Charles J. Martin  |  |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

|   |  |  |   |  |  |  |  |  |   |  |  |  |  |  |                  |  |  |                          |  |  |       |  |  |          |  |  |      |  |  |          |  |  |
|---|--|--|---|--|--|--|--|--|---|--|--|--|--|--|------------------|--|--|--------------------------|--|--|-------|--|--|----------|--|--|------|--|--|----------|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  |  | FIRST   |  |  | MIDDLE   |  |  | LAST  |  |  | 2a. DATE KNOWN OF DEATH                      |  |  | MONTH            |  |  | DAY                      |  |  | YEAR  |  |  | 2b. HOUR |  |  |      |  |  |          |  |  |
| JAMES   |  |  | F.  |  |  | SISTRUNK   |  |  |   |  |  | 2  |  |  | 11               |  |  | 19                       |  |  | 82    |  |  | M        |  |  |      |  |  |          |  |  |
| 3. SEX  |  |  | 4. RACE   |  |  | 5. DATE OF BIRTH   |  |  | 6. AGE (IN YEARS)   |  |  | IF UNDER 1 YR.                               |  |  | IF UNDER 24 HRS. |  |  | 7c. DATE PRONOUNCED DEAD |  |  | MONTH |  |  | DAY      |  |  | YEAR |  |  | 2d. HOUR |  |  |
| male  |  |  | negro   |  |  | 3 5 21   |  |  | 60 YRS.   |  |  |  |  |  |                  |  |  | 2                        |  |  | 11    |  |  | 19       |  |  | 82   |  |  | 6p M     |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  |  | 7b. CITIZEN OF WHAT COUNTRY?  |  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>   |  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |  |  |  |  |  |                  |  |  |                          |  |  |       |  |  |          |  |  |      |  |  |          |  |  |
| SOUTH CAROLINA  |  |  | USA   |  |  |  |  |  | Baltimore City  |  |  |  |  |  |                  |  |  |                          |  |  |       |  |  |          |  |  |      |  |  |          |  |  |
| 10. CITY OR TOWN OF DEATH   |  |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)   |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY                                   |  |  |  |  |  |                  |  |  |                          |  |  |       |  |  |          |  |  |      |  |  |          |  |  |
| Baltimore   |  |  | 1420 Druid Hill Ave.  |  |  |  |  |  |   |  |  |  |  |  |                  |  |  |                          |  |  |       |  |  |          |  |  |      |  |  |          |  |  |
| 13a. STATE  |  |  | 13b. COUNTY   |  |  | 13c. CITY OR TOWN  |  |  | 13d. INSIDE CITY LIMITS?  |  |  | 13e. STREET ADDRESS                          |  |  |                  |  |  |                          |  |  |       |  |  |          |  |  |      |  |  |          |  |  |
| MD  |  |  |   |  |  | BALTIMORE  |  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  | 1420 DRUID HILL AVE.                         |  |  |                  |  |  |                          |  |  |       |  |  |          |  |  |      |  |  |          |  |  |
| 14. FATHER'S NAME   |  |  | 15. MOTHER'S MAIDEN NAME  |  |  |  |  |  |   |  |  |  |  |  |                  |  |  |                          |  |  |       |  |  |          |  |  |      |  |  |          |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)  |  |  | 16b. SOCIAL SECURITY NO.  |  |  | 17. INFORMANT  |  |  | ADDRESS   |  |  |  |  |  |                  |  |  |                          |  |  |       |  |  |          |  |  |      |  |  |          |  |  |
| YES   |  |  | 248-30-6397   |  |  | ANNIE L. SISTRUNK  |  |  | 1420 DRUID HILL AVE.  |  |  |  |  |  |                  |  |  |                          |  |  |       |  |  |          |  |  |      |  |  |          |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |  |  | PART I DEATH WAS CAUSED BY:   |  |  | IMMEDIATE CAUSE (a)  |  |  | Arteriosclerotic cardiovascular disease                             |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |  |                  |  |  |                          |  |  |       |  |  |          |  |  |      |  |  |          |  |  |
| 4292  |  |  | DUE TO, OR AS A CONSEQUENCE OF  |  |  | (b)  |  |  | DUE TO, OR AS A CONSEQUENCE OF                                      |  |  |  |  |  |                  |  |  |                          |  |  |       |  |  |          |  |  |      |  |  |          |  |  |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.                                   |  |  | (c)   |  |  |  |  |  |   |  |  |  |  |  |                  |  |  |                          |  |  |       |  |  |          |  |  |      |  |  |          |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. |  |  |   |  |  |  |  |  |   |  |  |  |  |  |                  |  |  |                          |  |  |       |  |  |          |  |  |      |  |  |          |  |  |
| 19a. DATE OF OPERATION  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  |  | 20. AUTOPSY?   |  |  |   |  |  |  |  |  |                  |  |  |                          |  |  |       |  |  |          |  |  |      |  |  |          |  |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH             |  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR  |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)  |  |  |   |  |  |  |  |  |                  |  |  |                          |  |  |       |  |  |          |  |  |      |  |  |          |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)   |  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |  |   |  |  |  |  |  |                  |  |  |                          |  |  |       |  |  |          |  |  |      |  |  |          |  |  |
| 22a. I certify that I took charge of the remains described above, held on   |  |  | Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: |  |  | Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |  |   |  |  |  |  |  |                  |  |  |                          |  |  |       |  |  |          |  |  |      |  |  |          |  |  |
| ACTUAL SIGNATURE  |  |  | TITLE (SPECIFY)   |  |  | DATE SIGNED  |  |  |   |  |  |  |  |  |                  |  |  |                          |  |  |       |  |  |          |  |  |      |  |  |          |  |  |
| Ann M. Dixon, M.D.  |  |  | M.D. Assistant  |  |  | MEDICAL EXAMINER   |  |  | 2-12-82   |  |  |  |  |  |                  |  |  |                          |  |  |       |  |  |          |  |  |      |  |  |          |  |  |
| EXAMINER'S NAME (TYPE OR PRINT)   |  |  | ADDRESS   |  |  |  |  |  |   |  |  |  |  |  |                  |  |  |                          |  |  |       |  |  |          |  |  |      |  |  |          |  |  |
| 1402 BP   |  |  | 111 Penn St.  |  |  |  |  |  |   |  |  |  |  |  |                  |  |  |                          |  |  |       |  |  |          |  |  |      |  |  |          |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |  |  | 23b. DATE   |  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE                             |  |  |  |  |  |                  |  |  |                          |  |  |       |  |  |          |  |  |      |  |  |          |  |  |
| BURIAL  |  |  | 2/18/82   |  |  | MD. VETERANS CEMETERY  |  |  | CROWNSVILLE   |  |  |  |  |  |                  |  |  |                          |  |  |       |  |  |          |  |  |      |  |  |          |  |  |
| 24. FUNERAL DIRECTOR NAME   |  |  | ADDRESS   |  |  | 25a. DATE REC'D. BY REGISTRAR  |  |  | 25b. REGISTRAR'S SIGNATURE  |  |  |  |  |  |                  |  |  |                          |  |  |       |  |  |          |  |  |      |  |  |          |  |  |
| WM. C. MARCH F/H  |  |  | 1101 E. NORTH AVENUE  |  |  | FEB 16 1982  |  |  | Name [Signature]  |  |  |  |  |  |                  |  |  |                          |  |  |       |  |  |          |  |  |      |  |  |          |  |  |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR RECORDS. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

2003年11月

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 4 1 9 7

|   |  |  |  |
|---|--|--|--|
| 1. FOR STATE REGISTRAR  |  | REG. NO.   |  |
| 1. DECEASED NAME (TYPE OR PRINT)  |  | 2a. DATE OF DEATH  |  |
| FIRST MIDDLE LAST<br>RUTH V. SLAVICH  |  | MONTH DAY YEAR<br>2 7 82   |  |
| 3. SEX  |  | 7b. HOUR   |  |
| ♀   |  | 3:08 PM  |  |
| 4. RACE   |  | 6. AGE (IN YEARS LAST BIRTHDAY)  |  |
| W   |  | 68 YRS   |  |
| 5. DATE OF BIRTH  |  | IF UNDER 1 YEAR  |  |
| MONTH DAY YEAR<br>7 18 13   |  | MONTHS DAYS HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  | 9. BALTIMORE CITY OR COUNTY OF DEATH   |  |
| Wash. DC.   |  | Balt. City MD.   |  |
| 7b. CITIZEN OF WHAT COUNTRY?  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |  |
| USA   |  | housewife  |  |
| 10. CITY OR TOWN OF DEATH   |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| Balt  |  | household  |  |
| 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)  |  | 13a. STREET ADDRESS  |  |
| SBGH  |  | 2307 Four Seasons Dr.  |  |
| 13b. INSIDE CITY LIMITS?  |  | 13c. STREET ADDRESS  |  |
| YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 2307 Four Seasons Dr.  |  |
| 14. FATHER'S NAME   |  | 15. MOTHER'S MAIDEN NAME   |  |
| FIRST MIDDLE LAST<br>Clearance Nolan  |  | FIRST MIDDLE LAST<br>Lula Rogers   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)   |  | 16b. SOCIAL SECURITY NO.   |  |
| no  |  | 445-62-6941  |  |
| 17. INFORMANT   |  | ADDRESS  |  |
| Michael Slavich same as 13c.  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:   |  |  |  |
| IMMEDIATE CAUSE (a) <u>Respiratory arrest</u>   |  |  |  |
| 1629 DUE TO, OR AS A CONSEQUENCE OF   |  |  |  |
| (b) <u>Oat Cell Carcinoma of LUNG</u>   |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF  |  |  |  |
| (c)   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I:                  |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |
|   |  |  |  |
| 20a. AUTOPSY?   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?   |  |
| YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) |  | 21b. TIME OF INJURY  |  |
|   |  | HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |  |  |  |
| 21d. INJURY OCCURRED  |  | 21e. PLACE OF INJURY   |  |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  |
| 21f. LOCATION   |  | CITY OR TOWN COUNTY STATE  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from above, (I) (we) (did) (did not) view the body after death.                     |  | 22b. SIGNATURE   |  |
| 22c. DATE SIGNED  |  | DEGREE   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  |
| 22e. ADDRESS  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |  | 23b. DATE  |  |
| Burial  |  | 2/11/82  |  |
| 23c. NAME OF CEMETERY OR CREMATORY  |  | 23d. LOCATION  |  |
| Ft Lincoln Cemetery   |  | Brentwood MD   |  |
| 24. FUNERAL DIRECTOR  |  | 25a. DATE REC'D. BY REGISTRAR  |  |
| NAME ADDRESS<br>Hardesty Funeral Home 12 Ridgely Ave. Ann. Md.  |  | FEB 9 1982   |  |

MEDICAL CERTIFICATION

19



FEB 2 1985  
JAN 1985



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be retained by the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |   |  |   |  |  |                                   | REG. NO. 8 2 0 4 1 9 3                       |  |
|--|--|--|--|---|--|---|--|--|-----------------------------------|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Edith Marie Smallwood</b>   |  |  |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>2 - 02 - 82</b>  |  |  | 2b. HOUR<br><b>9:45 p.m.</b>      |  |  |
| 3. SEX<br><b>Female</b>  |  | 4. RACE<br><b>White</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Nov. 15, 1895</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>86</b> YRS.   |  | IF UNDER 1 YEAR<br>MONTHS DAYS   |                                   | IF UNDER 24 HRS.<br>HOURS MIN.               |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.                               |  |  |                                   |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Midtown Home, Inc.</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Sales Lady Ret.</b>      |  |  | 12b. KIND OF BUSINESS OR INDUSTRY |  |  |
| 13a. STATE<br><b>Maryland</b>  |  | 13b. COUNTY  |  | 13c. CITY OR TOWN<br><b>Baltimore</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>Balt., Md. 21218<br/>2793 Alameda</b>  |                                   |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Williams</b>  |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Not Known</b>   |  |   |  |  |                                   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)   |  | 16b. SOCIAL SECURITY NO.<br><b>216-09-2587</b>   |  | 17. INFORMANT<br><b>Son: Edgar Smallwood</b>  |  |   |  | ADDRESS<br><b>Balt., Md. 21218<br/>2793 Alameda</b>  |                                   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiopulmonary Arrest</b><br><b>4292</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>placental Cordocentesis</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |  |  |   |  |   |  |  |                                   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c)  |  |  |  |   |  |   |  |  |                                   |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                                   |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART I OR PART 2)  |  |   |  |  |                                   |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |  |                                   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>1-21</b> 19 <b>82</b> , to <b>2-2</b> 19 <b>82</b> , that (I) (we) last saw the deceased alive on <b>2-2</b> 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                       |  |  |  |   |  |   |  |  |                                   |  |  |
| 22b. SIGNATURE<br><b>[Signature]</b>   |  | DEGREE   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                  |  |   |  | 22c. DATE SIGNED<br><b>2-3-82</b>  |                                   |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>RUBEN REIDER MD</b>  |  | 22e. ADDRESS<br><b>1406 Grain Highway South, Suite 102<br/>Baltimore, Md 21061</b>   |  |   |  |   |  |  |                                   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>Feb 5, 1982</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Loudon Park</b>  |  |   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Maryland</b>  |                                   |  |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Leonard J. Ruck, Inc. Baltimore, Maryland</b>   |  |  |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>FEB 4 1982</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>   |                                   |  |  |

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 4 1 9 9

FOR  
STATE  
REGISTRAR

REG. NO.

|  |  |   |   |   |  |  |   |   |  |   |  |
|--|--|---|---|---|--|--|---|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>CORNELIA D. SMITH</b>   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>2/26/82</b>                   |   |  | 2b. HOUR<br><b>4:30 A.M.</b>   |   |   |  |   |  |
| 3. SEX<br><b>F</b>   |  | 4. RACE<br><b>BIK</b>   |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>1-7-12</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>70</b>   |   | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.<br><b>YRS.</b>  |  |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MD</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A</b>  |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>City</b> MD.  |   |   |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Balto</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Bon Secour Hosp</b> |   |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)   |   | 12b. KIND OF BUSINESS OR INDUSTRY   |  |   |  |
| 13a. STATE<br><b>MD</b>  |  |   | 13b. COUNTY   |   | 13c. CITY OR TOWN<br><b>Balto</b>                        |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   | 13e. STREET ADDRESS<br><b>2403 W. LANVALE ST</b>                                 |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Linton Davis</b>  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Virginia Carter</b> |   |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)   |   |   |  | 16b. SOCIAL SECURITY NO.<br><b>215-032387</b> |  |
| 17. INFORMANT<br><b>Luther Smith</b>   |  |   | ADDRESS<br><b>2403 W. LANVALE ST</b>                                    |   |  |  |   |   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>RESPIRATORY ARREST</b><br><b>2500</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>MASSIVE CEREBROVASCULAR</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Ischaemic mellitus - ACCIDENT</b><br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) |  |   |   |   |  |  |   |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br><b>2 days</b><br><b>years</b> |   |  |
| 19a. DATE OF OPERATION   |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                        |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |   | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)  |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>       |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |   |   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |   |   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>2/19/82</b> , to <b>2/26/82</b> , that (I) (we) lost<br>saw the deceased alive on <b>2/26/82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.   |  |   |   |   |  |  |   |   |  |   |  |
| 22b. SIGNATURE<br><b>M. Dunn</b>   |  |   | DEGREE<br><b>MD</b>   |   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   |   | 22c. DATE SIGNED<br><b>2/26/82</b>   |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>MANCOURN F. ARBUTHNOT</b>  |  |   | 22e. ADDRESS<br><b>1940 W. Balto St Balto Md 23</b>                     |   |  |  |   |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>  |  |   | 23b. DATE<br><b>3-1-82</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Arbutus Cem</b> |  |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Balto</b>  |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>VERNON BALIEY</b>   |  |   | ADDRESS<br><b>1348 CALHOUN ST</b>                                       |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>MAR 2 1982</b>   |   |   |  |   |  |

Herbert A. Johnson

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Herbert A. Johnson

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

|   |  |  |   |  |  |   |  |  |   |  |  |   |  |  |                                |  |  |            |  |  |   |  |  |   |  |  |                         |  |  |
|---|--|--|---|--|--|---|--|--|---|--|--|---|--|--|--------------------------------|--|--|------------|--|--|---|--|--|---|--|--|-------------------------|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  |  | FIRST<br>DANIEL   |  |  | MIDDLE<br>W.  |  |  | LAST<br>SMITH   |  |  | 2a. DATE KNOWN<br>OF DEATH                |  |  | ESTI-<br>MATED                 |  |  | MONTH<br>2 |  |  | DAY<br>6  |  |  | YEAR<br>19 82                                   |  |  | 2b. HOUR<br>M           |  |  |
| 3. SEX<br>male  |  |  | 4. RACE<br>negro  |  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>8 9 1950  |  |  | 6. AGE (IN YEARS<br>LAST BIRTHDAY)<br>31 YRS.   |  |  | IF UNDER 1 YR.<br>MONTHS DAYS HOURS MIN   |  |  | 7c. DATE<br>PRONOUNCED<br>DEAD |  |  | MONTH<br>2 |  |  | DAY<br>6  |  |  | YEAR<br>19 82                                   |  |  | 2d. HOUR<br>8:55<br>P M |  |  |
| 7a. BIRTHPLACE (STATE OR<br>FOREIGN COUNTRY)<br>Md  |  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD                                       |  |  |   |  |  |                                |  |  |            |  |  |   |  |  |   |  |  |                         |  |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore  |  |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>University Hospital (DOA) |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK<br>FOR MOST OF WORKING LIFE)  |  |  | 12b. KIND OF BUSINESS<br>OR INDUSTRY  |  |  |   |  |  |                                |  |  |            |  |  |   |  |  |   |  |  |                         |  |  |
| 13a. STATE<br>Md  |  |  | 13b. COUNTY   |  |  | 13c. CITY OR TOWN<br>Baltimore  |  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  | 13e. STREET ADDRESS<br>2614 Violet Avenue |  |  |                                |  |  |            |  |  |   |  |  |   |  |  |                         |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Daniel R. Smith Sr  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Naomi Warren   |  |  |   |  |  |   |  |  |   |  |  |                                |  |  |            |  |  |   |  |  |   |  |  |                         |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br>Yes  |  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>216-50-2739  |  |  | 17. INFORMANT ADDRESS<br>Shelly Smith 2614 Violet Avenue  |  |  |   |  |  |   |  |  |                                |  |  |            |  |  |   |  |  |   |  |  |                         |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Intravenous narcotism</u><br>3049<br>Conditions, if any, which<br>gave rise to immediate<br>cause (a) stating the under-<br>lying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>DUE TO, OR AS A CONSEQUENCE OF  |  |  |   |  |  |   |  |  |   |  |  |   |  |  |                                |  |  |            |  |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH                                     |  |  |   |  |  |                         |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).   |  |  |   |  |  |   |  |  |   |  |  |   |  |  |                                |  |  |            |  |  |   |  |  |   |  |  |                         |  |  |
| 19a. DATE OF OPERATION  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  |  |   |  |  |   |  |  |   |  |  |                                |  |  |            |  |  | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |   |  |  |                         |  |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR<br>CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |  |  |   |  |  |   |  |  |                                |  |  |            |  |  |   |  |  |   |  |  |                         |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  |  | 21e. PLACE OF INJURY (AT HOME,<br>STREET, FACTORY, FARM, ETC.)  |  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |   |  |  |   |  |  |                                |  |  |            |  |  |   |  |  |   |  |  |                         |  |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion<br>death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |  |   |  |  |   |  |  |   |  |  |   |  |  |                                |  |  |            |  |  |   |  |  |   |  |  |                         |  |  |
| ACTUAL<br>SIGNATURE   |  |  | TITLE (SPECIFY)<br>Assistant MEDICAL EXAMINER   |  |  |   |  |  |   |  |  |   |  |  |                                |  |  |            |  |  | DATE<br>SIGNED 2-7-82   |  |  |   |  |  |                         |  |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)  |  |  | Ann M. Dixon, M.D.  |  |  |   |  |  |   |  |  |   |  |  |                                |  |  |            |  |  | ADDRESS<br>111 Penn St.   |  |  |   |  |  |                         |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial  |  |  | 23b. DATE<br>2/11/82  |  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Arbutus Mem Park  |  |  | 23d. LOCATION<br>CITY OR TOWN<br>Arbutus  |  |  | COUNTY<br>Md                              |  |  |                                |  |  |            |  |  |   |  |  |   |  |  |                         |  |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS  |  |  | William C. March F/H 1101 E. North Avenue   |  |  |   |  |  |   |  |  |   |  |  |                                |  |  |            |  |  | 25a. DATE REC'D. BY REGISTRAR<br>FEB 9 1982   |  |  | 25b. REGISTRAR'S SIGNATURE<br>Charles J. Nathan |  |  |                         |  |  |

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DHMH-17  
(VR A15 ME (5))  
15M 2/80



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

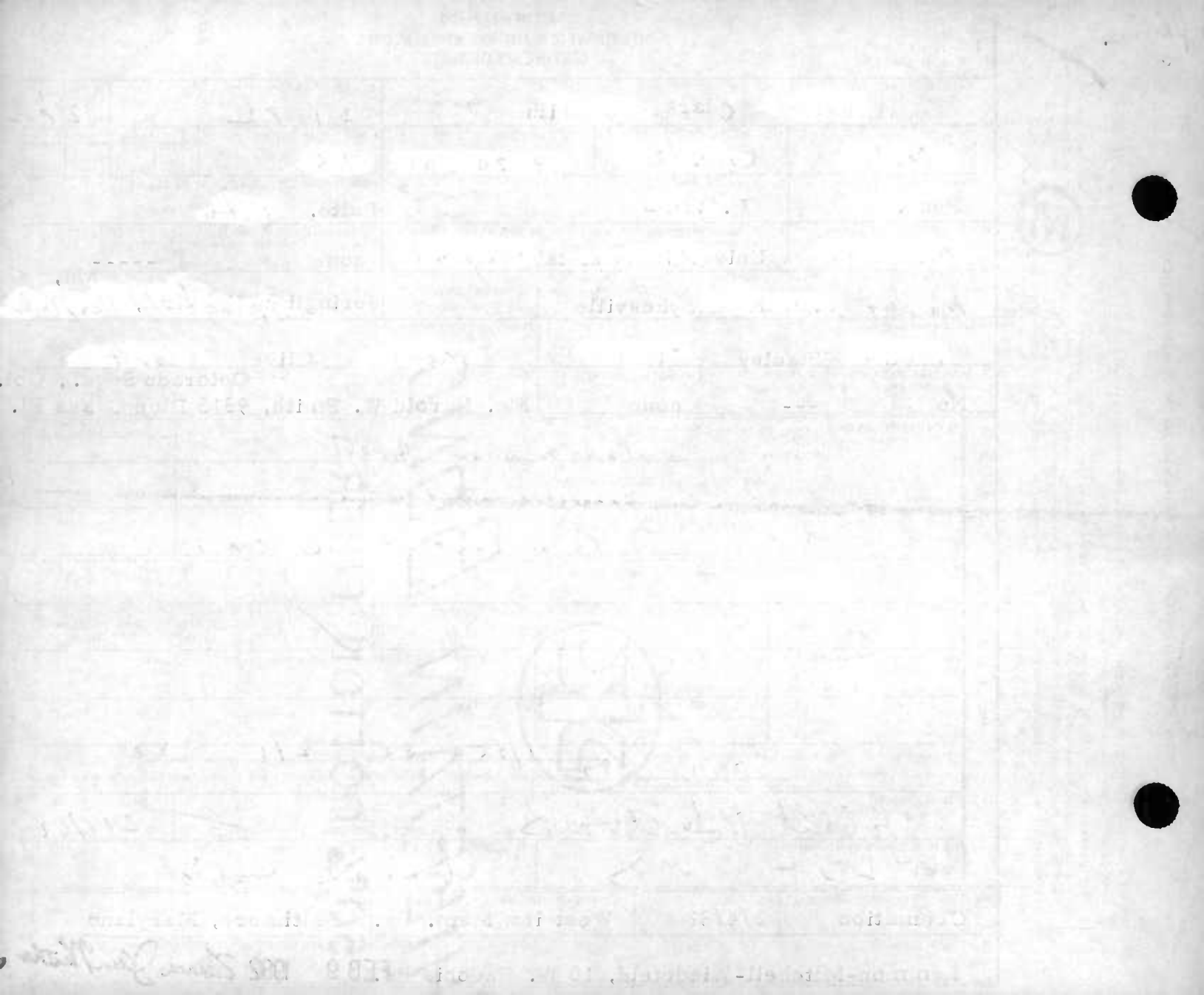
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in the office of the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  | 8 2 0 4 2 0 1  |  |   |  |
|--|--|---|--|--|--|---|--|
| 1. FOR STATE REGISTRAR   |  |   |  | REG. NO.   |  |   |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) Edward Clark Smith   |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR 2/1/82  |  |   |  |
| 3. SEX Male  |  | 4. RACE Cauc.   |  | 5. DATE OF BIRTH MONTH DAY YEAR 9 20 1908  |  | 6. AGE (IN YEARS LAST BIRTHDAY) 73 YRS.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Penn.  |  | 7b. CITIZEN OF WHAT COUNTRY? U.S.A.   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH Balto. City MD   |  |
| 10. CITY OR TOWN OF DEATH Baltimore  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH STREET ADDRESS) University Hospital |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) none   |  | 12b. KIND OF BUSINESS OR INDUSTRY -----   |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION) (RESIDENCE BEFORE ADMISSION) 13b. STATE Maryland 13c. CITY OR TOWN Sykesville  |  |   |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>  |  |   |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST Edward Stanley Smith   |  |   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Olive Clark  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No ---   |  |   |  | 16b. SOCIAL SECURITY NO. none  |  |   |  |
| 17. INFORMANT Mr. Harold W. Smith, 9515 Blue Grass Pl.   |  |   |  | 18. ADDRESS Colorado Spgs., Col.   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardiopulmonary Arrest</u><br>DUE TO, OR AS A CONSEQUENCE OF (b) <u>Congestive Heart Failure</u><br>DUE TO, OR AS A CONSEQUENCE OF (c) <u>Chronic Lymphocytic Leukemia</u><br>2041 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last |  |   |  |  |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 10  |  |   |  |  |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 1/25, 19 82, to 2/1, 19 82, that (I) (we) lost saw the deceased alive on 2/1, 19 82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |   |  |  |  |   |  |
| 22b. SIGNATURE Robert H. Levitt  |  |   |  | DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                   |  | 22c. DATE SIGNED 2/1/82   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Robert L. Levitt   |  |   |  | 22e. ADDRESS University Hospital   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation  |  | 23b. DATE 2/4/82  |  | 23c. NAME OF CEMETERY OR CREMATORY Westview Mem. Pk.   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Maryland   |  |
| 24. FUNERAL DIRECTOR NAME ADDRESS Lemmon-Mitchell-Wiedefeld, 10 W. Padonia Rd.   |  |   |  | 25a. DATE REC'D. BY REGISTRAR FEB 9 1982   |  |   |  |
|  |  |   |  | 25b. REGISTRAR'S SIGNATURE Frances Jean Nether   |  |   |  |





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 4 2 0 2

|  |  |  |  |
|--|--|--|--|
| 1. FOR<br>STATE<br>REGISTRAR   |  | REG. NO.   |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Edward L. SMITH   |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>February 28, 1982  |  |
| 3 SEX<br>Male  |  | 2b. HOUR<br>12:20 <sup>a</sup> M   |  |
| 4 RACE<br>Black  |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br>65   |  |
| 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>1 4 17   |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>VA  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |  |
| 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>   |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.   |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Maryland General Hospital               |  |
| 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)   |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13a. STATE<br>MD   |  | 13b. COUNTY<br>Baltimore   |  |
| 13c. CITY OR TOWN<br>Baltimore   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |
| 13e. STREET ADDRESS<br>2017 Monroe St.   |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Jack Smith   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Edna  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No   |  | 16b. SOCIAL SECURITY NO.<br>115-03-1646  |  |
| 17. INFORMANT<br>ADDRESS<br>Jesse Thomas 3404 Glen Avenue  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Respiratory Arrest<br>1850<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) Renal Failure<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) Carcinoma of the Prostate--Metastatic  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br>Hematuria from the Carcinoma of the Prostate.   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |
| 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                           |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  |
| 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |  |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from February 11, 1982, to February 28, 1982, that <input checked="" type="checkbox"/> (we) lost the deceased alive on February 28, 1982, and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) did <input type="checkbox"/> (did not) view the body after death. |  |  |  |
| 22b. SIGNATURE<br>Prasad M.D.  |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  |
| 22c. DATE SIGNED<br>2/28/82  |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Kirshna Prasad, M.D.  |  | 22e. ADDRESS<br>c/o Maryland General Hospital  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial   |  | 23b. DATE<br>3/5/82  |  |
| 23c. NAME OF CEMETERY OR CREMATORY<br>Mt. Auburn Cem.  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore MD   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Wm. C. March F/H   |  | 25a. DATE REC'D. BY REGISTRAR<br>MAR 2 1982  |  |
| ADDRESS<br>1101 E. North Ave.  |  | 25b. REGISTRAR'S SIGNATURE<br>Charles J. Nathan  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, this page should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 50M 1/81  
(VRA 15, 4)

1- FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |   |   |  |  |
|---|--|---|---|--|--|
| 1. DECEASED NAME<br>(TYPE OF NAME)<br><b>Edward R. Smith</b>  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>2-19-82</b>   |   | 2b. HOUR<br><b>7:29p</b>   |  |
| 3 SEX<br><b>Male</b>  | 4. RACE<br><b>Black</b>  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>2 4 05</b>   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>77</b> YRS.                                    |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MD</b>  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD                     |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN FACILITY, GIVE STREET ADDRESS)<br><b>John Hopkins Hospital</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)                                |  | 12b. KIND OF BUSINESS OR INDUSTRY                            |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |   |   |  |  |
| 13a. STATE<br><b>MD</b>   | 13b. COUNTY  | 13c. CITY OR TOWN<br><b>Baltimore</b>   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS<br><b>2200 E. Biddle St.</b>                                     |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Melvin Smith</b>   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Rosetta Keller</b>  |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>No</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>213-10-4912</b>  |   | 17. INFORMANT ADDRESS<br><b>Julia A. Smith 2200 E. Biddle St.</b>                    |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Respiratory Arrest</b><br><b>7991</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |   |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>5 min</b> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)  |  |   |   |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/><br>AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>8/2/11/82</b> , 19 <b>82</b> , to <b>2/19</b> , 19 <b>82</b> , that (I) (we) last saw the deceased alive on <b>2/19</b> , 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |   |   |  |  |
| 22b. SIGNATURE<br><b>Mark G. Midei</b>  |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>        |   | 22c. DATE SIGNED<br><b>2/19/82</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>M. G. Midei</b>   |  | 22e. ADDRESS<br><b>600 N. Wolfe St. Balt. MD 21205</b>  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>2/23/82</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Mt. Auburn Cem.</b>                         |  |
| 23d. LOCATION<br>CITY OR TOWN<br><b>Baltimore</b>   |  | COUNTY<br><b>MD</b>   |   | STATE  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Wm. C. March F/H</b>   |  | ADDRESS<br><b>1101 E. North Ave.</b>  |   | 25a. DATE REC'D. BY REGISTRAR<br><b>FEB 24 1982</b>                                  |  |
| 25b. REGISTRAR'S SIGNATURE<br><b>Thomas J. [Signature]</b>  |  |   |   |  |  |

MEDICAL CERTIFICATION



1912

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  | 8 2 - 0 4 2 0 4   |  |  |  |
|--|--|--|--|---|--|--|--|
| 1- FOR STATE REGISTRAR   |  |  |  | REG. NO.  |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Elaine Smith</b>  |  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>February 4, 1982</b>  |  |  |  |
| 3. SEX<br><b>Female</b>  |  | 4. RACE<br><b>Black</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>5 5 21</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>60</b> YRS.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MD</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>3551 Flannery Lane</b> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE <b>MD</b> 13b. COUNTY <b>Baltimore</b> 13c. CITY OR TOWN <b>Lochearn</b>   |  |  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 13e. STREET ADDRESS<br><b>3551 Flannery Lane</b>   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Charles Cooper</b>  |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Ruth Roberts</b>  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>212-26-7334</b>   |  | 17. INFORMANT<br>ADDRESS<br><b>Esther Jackson 7900 Dunhill Village</b>  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Adeno carcinoma stomach</b><br><b>1519</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |  |  |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>4 mo.</b> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a):   |  |  |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>Sept 19 81</b> , to <b>Feb 19 82</b> , that (I) (we) last saw the deceased alive on <b>Jan 25 19 82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                       |  |  |  |   |  |  |  |
| 22b. SIGNATURE<br><b>Mary Carroll</b>  |  |  |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>        |  | 22c. DATE SIGNED<br><b>2/4/82</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>MARY CARROLL</b>   |  |  |  | 22e. ADDRESS<br><b>MERCY HOSPITAL, BALTO. MD.</b>   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>2/8/82</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Woodlawn Cem.</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Co. MD</b>  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Wm. C. March F/H</b>  |  |  |  | ADDRESS<br><b>1101 E. North Ave.</b>  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>FEB 9 1982</b>   |  |
|  |  |  |  | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>  |  |  |  |





BP  
DHMH - 16 50M 1/81  
(VRA 15, 4)

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| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |  |  |  |  |   |  |  |
|--|--|--|--|--|--|--|--|---|--|--|
| 1. FOR STATE REGISTRAR   |  | REG. NO. 8 2 0 4 2 0 5   |  |  |  |  |  |   |  |  |
| 1. DECEASED NAME (TYPE OR PRINT)   |  | FIRST EUGENE   |  | MIDDLE C.  |  | LAST SMITH   |  | 2a. DATE OF DEATH MONTH DAY YEAR 02 20 82   |  | 2b. HOUR 3:30 PM                             |
| 3. SEX Male  |  | 4. RACE Caucasian  |  | 5. DATE OF BIRTH MONTH DAY YEAR 06 14 18   |  | 6. AGE (IN YEARS LAST BIRTHDAY) 63 YRS.  |  | IF UNDER 1 YEAR MONTHS DAYS   |  | IF UNDER 24 HRS. HOURS MIN.                  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia   |  | 7b. CITIZEN OF WHAT COUNTRY? U.S.A.  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.                                    |  |   |  |  |
| 10. CITY OR TOWN OF DEATH Baltimore  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) South Baltimore General |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Fork Lift Oper.              |  | 12b. KIND OF BUSINESS OR INDUSTRY Exxon Chem  |  |  |
| 13a. STATE Maryland  |  | 13b. COUNTY Anne Arundel   |  | 13c. CITY OR TOWN Glen Burnie  |  | 13d. INSIDE CITY LIMITS? <input type="checkbox"/> NO <input checked="" type="checkbox"/> X |  | 13e. STREET ADDRESS 6646 Whitmore Ct 138B   |  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST Loan A Smith   |  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Huldah Plott  |  |  |  | 16. ADDRESS 6646 Whitmore Ct 138B   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes  |  | (IF YES, GIVE WAR OR DATES) WW II  |  | 16b. SOCIAL SECURITY NO. 226-14-2105   |  | 17. INFORMANT Nellie Smith Glen Burnie, Md. 21061  |  |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 1734 IMMEDIATE CAUSE (a) Respiratory Arrest. #   |  |  |  |  |  |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Metastatic squamous cell carcinoma of head and neck   |  |  |  |  |  |  |  |   |  | 4 years.                                     |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Chronic Lymphocytic Leukemia.  |  |  |  |  |  |  |  |   |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>                     |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)   |  |  |  |   |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |  |  |   |  |  |
| 22a. I certify that (1) this hospital attended the deceased from 2/20, 19 82, to 2/20, 19 82, that (1) (we) last saw the deceased alive on 2/20, 19 82, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) did not view the body after death. |  |  |  |  |  |  |  |   |  |  |
| 22b. SIGNATURE K.S. Gummerson PHDMD  |  |  |  | DEGREE PHDMD   |  |  |  | 22c. DATE SIGNED 2/20/82  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) K.S. Gummerson PHDMD   |  |  |  | 22e. ADDRESS SBGM.   |  |  |  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial   |  | 23b. DATE 2/24/82  |  | 23c. NAME OF CEMETERY OR CREMATORY Meadowridge Mem   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Howard Md.                               |  |   |  |  |
| 24. FUNERAL DIRECTOR Alex C. Laurel Funeral Home Inc. 7601 Sandy Spring Rd. Laurel Md 20707  |  |  |  | 25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE FEB 22 1982   |  |  |  |   |  |  |

MEDICAL CERTIFICATION



BP

DHMM-16 30M 2/80  
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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added info g566 4/22/82 gj

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 4 2 0 6

REG. NO.

|  |  |  |  |   |                               |  |
|--|--|--|--|---|-------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>FRANK A. SMITH</b>  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>02-10-82</b> |   | 2b. HOUR<br><b>11 55 P.M.</b> |  |
| 3. SEX<br><b>MALE</b>  |  | 4. RACE<br><b>BLACK</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>MAY 20, 1921</b>   |                               |  |
| 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>60</b> YRS.  |  | IF UNDER 1 YEAR<br>MONTHS DAYS   |  | IF UNDER 24 HRS.<br>HOURS MIN.  |                               |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>CROOME, MARYLAND</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                               |  |
| 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.  |  |  |  |   |                               |  |
| 10. CITY OR TOWN OF DEATH<br><b>CITY</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>THE UNION MEMORIAL HOSPITAL</b>          |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>LABORER</b>  |                               |  |
| 12b. KIND OF BUSINESS OR INDUSTRY  |  | 13a. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 13b. STREET ADDRESS<br><b>8901 Duvall Rd Upper Marlboro</b> Md  |                               |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>MARYLAND</b>  |  | 13b. COUNTY<br><b>PRINCE GEORGES</b>   |  | 13c. CITY OR TOWN   |                               |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>JAMES SMITH</b>   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>MARY BERRY</b>   |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>No</b>   |                               |  |
| 16b. SOCIAL SECURITY NO.<br><b>217-14-7377</b>   |  | 17. INFORMANT<br><b>Gladys G. Swann Upper Marlboro, Maryland</b>   |  |   |                               |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>RESPIRATORY ARREST</b><br><b>5789</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>ACUTE GI BLOOD LOSS</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Alcoholism</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |  |  |   |                               |  |
| APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>12 hrs</b>  |  |  |  |   |                               |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |  |  |   |                               |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                               |  |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER) |  |   |                               |  |
| 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)  |  |   |                               |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |                               |  |
| 22a. I certify that (1) (this hospital) attended the deceased from <b>ON 2-10, 19 82</b> , to <b>2-10, 19 82</b> , that (2) (we) lost saw the deceased alive on <b>2-10, 19 82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) (did not) view the body after death.  |  |  |  |   |                               |  |
| 22b. SIGNATURE<br><b>Robert J. Caviglia</b>  |  | 22c. DATE SIGNED<br><b>2/11/82</b>   |  | 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Robert J. Caviglia</b>  |                               |  |
| 22e. ADDRESS<br><b>4339 Arundel Ave</b>  |  | 22f. DATE REC'D. BY REGISTRAR<br><b>FEB 11 1982</b>  |  |   |                               |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>2/15/82</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Harmony Mem. Pl. Cemetery, Inc.</b>  |                               |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Harmony Mem. Pl. Cemetery, Inc. Prince Georges County Md</b>  |  | 23e. DATE REC'D. BY REGISTRAR<br><b>FEB 11 1982</b>  |  |   |                               |  |
| 23f. REGISTRAR'S SIGNATURE<br><b>Francis J. ...</b>  |  | 23g. REGISTRAR'S SIGNATURE<br><b>Francis J. ...</b>  |  |   |                               |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrars, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of this.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  |  |  |  |  |   |  |  |
|---|--|--|--|--|--|--|--|---|--|--|
| 1. FOR STATE REGISTRAR  |  |  |  |  | REG. NO.   |  |  |   |  |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>HARRY H. SMITH</b>  |  |  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>2 26 82</b>  |  | 2b. HOUR<br><b>9 A M</b>   |   |  |  |
| 3. SEX<br><b>MALE</b>   |  | 4. RACE<br><b>WHITE</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>09 12 24</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>57</b> YRS.                                    |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.   |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>GEORGIA</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City MD.</b>                    |  |   |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>University of Maryland Hosp</b> |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>LINEMAN</b>      |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>GAS &amp; ELECTRIC</b>  |  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>MARYLAND</b>   |  |  |  |  | 13b. COUNTY<br><b>---</b>  |  | 13c. CITY OR TOWN<br><b>BALTIMORE</b>  |   | 13d. INSIDE CITY LIMITS?<br><b>NO</b>                        |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>JOHN A. SMITH</b>  |  |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>OLA MAE BURANEN</b>  |  |  |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><b>YES</b>   |  |  | 16b. SOCIAL SECURITY NO.<br><b>WW II 219-18-4695</b>               |  | 17. INFORMANT ADDRESS<br><b>ROSE Z. SMITH 1347 GLYNDON AVENUE, 21223</b>   |  |  |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>cardio pulmonary arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>laryngeal carcinoma</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>hepatoma</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |  |  |  |  |  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>6 yrs</b> |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)   |  |  |  |  |  |  |  |   |  |  |
| 19a. DATE OF OPERATION<br><b>none</b>   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                   |  |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b. PART 1 OR PART 2)   |  |  |   |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |  | 21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>2-24</b> 19 <b>82</b> , to <b>2-26</b> 19 <b>82</b> , that (I) (we) last saw the deceased alive on <b>2-25</b> 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                  |  |  |  |  |  |  |  |   |  |  |
| 22b. SIGNATURE<br><b>Linda Headrick MD</b>  |  |  |  |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  |  | 22c. DATE SIGNED<br><b>2-26-82</b>  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Linda Headrick MD</b>   |  |  |  |  | 22e. ADDRESS<br><b>22 S. Greene St Baltimore 21201</b>   |  |  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>BURIAL</b>  |  |  | 23b. DATE<br><b>03-01-82</b>                                       |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>LOUDON PARK</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>BALTIMORE CITY MARYLAND</b> |   |  |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>HUBBARD FUNERAL HOME, INC. 4107 WILKENS AVE. 21229</b>   |  |  |  |  | 25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR<br><b>MAR 1 1982 Frances Jan Nathan</b>   |  |  |   |  |  |

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U.S. DEPARTMENT OF JUSTICE  
FEDERAL BUREAU OF INVESTIGATION  
WASHINGTON, D.C. 20535  
MAY 2 1964  
COMMUNICATIONS SECTION  
TELETYPE UNIT  
TO DIRECTOR  
FROM SAC, NEW YORK  
SUBJECT: [illegible]  
RE: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director (page 3) should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 4 2 0 8

REG. NO.

|  |   |   |  |   |  |
|--|---|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <u>John</u> <u>Smith</u>   |   |   | 2a. DATE OF DEATH MONTH DAY YEAR<br><u>2</u> <u>28</u> <u>82</u>                   |   | 2b. HOUR<br><u>2:30 pm</u>   |
| 3. SEX<br><u>M</u>   | 4. RACE<br><u>BIK</u>   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><u>7</u> <u>10</u> <u>1904</u>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><u>77</u> YRS.   | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><u>VA.</u>  | 7b. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.</u>   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><u>CITY</u> MD.   |  |
| 10. CITY OR TOWN OF DEATH<br><u>Balto.</u>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><u>BALTO CITY Hospital</u> |   | 12a. USUAL OCCUPATION<br>(TYPE OR WORK FOR MOST OF WORKING LIFE)<br><u>JANITOR</u> |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><u>HOUSING</u>  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE <u>Md.</u> 13b. COUNTY <u>BALTO</u> 13c. CITY OR TOWN <u>Turners</u>  |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   | 13e. STREET ADDRESS<br><u>201 Sollores Pt. Rd.</u>                                 |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><u>Edd.</u> <u>Smith</u>   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><u>Queen</u> <u>Smith</u>  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><u>No</u>  |   | 16b. SOCIAL SECURITY NO.<br><u>216-07-8864</u>  | 17. INFORMANT<br>ADDRESS<br><u>Ernest Foulkes, 201 Sollores Pt.</u>                |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>cardiopulm. arrest</u><br><u>4275</u> DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)<br>DUE TO, OR AS A CONSEQUENCE OF (c)          |   |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |   |   |  |   |  |
| 19a. DATE OF OPERATION   |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                     | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><u>P.M.</u> <u>19</u>  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART I OR PART 2)     |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>2/6/82</u> 19 <u>82</u> to <u>2/28</u> 19 <u>82</u> , that (I) (we) last saw the deceased alive on <u>2/28</u> 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |   |   |  |   |  |
| 22b. SIGNATURE<br><u>Bram Foulkes</u>  |   | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>        |  |   | 22c. DATE SIGNED<br><u>4/28/82</u>   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>Bram Foulkes</u>   |   | 22e. ADDRESS<br><u>Balt. City Hosp.</u>   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br><u>Burial</u>   | 23b. DATE<br><u>3/4/82</u>  | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Smith's Cem.</u>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><u>VICTORIA, VA.</u>  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><u>James A. Morton &amp; Sons</u>  |   | ADDRESS<br><u>1701 Laurens St.</u>  |  | 25a. DATE REC'D. BY REGISTRAR<br><u>MAR 5 1982</u><br>25b. REGISTRAR'S SIGNATURE<br><u>Frances Jan Nathan</u> |  |





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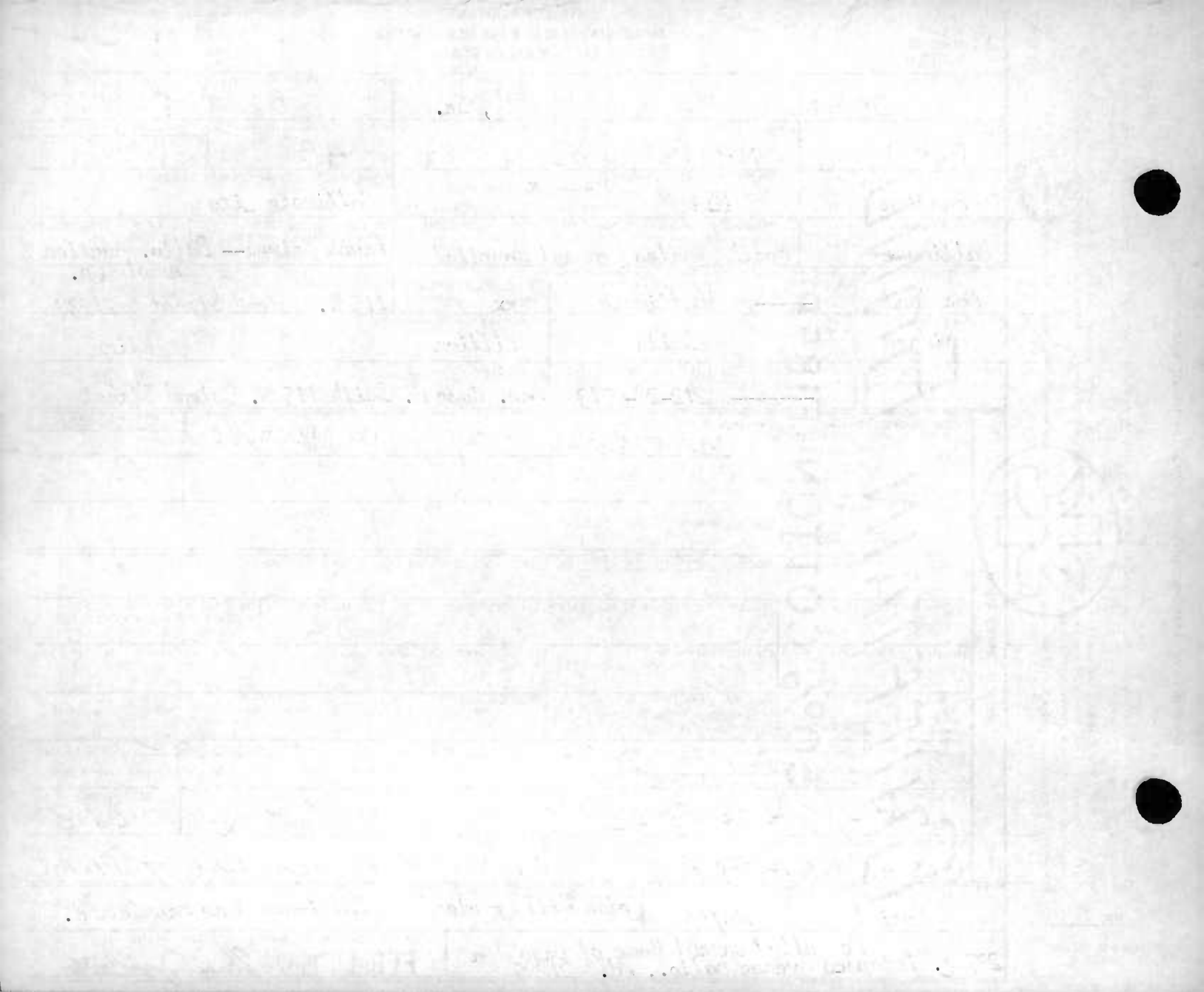
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  | REG. NO.<br>8 2 0 4 2 0 9   |  |  |  |
|---|--|---|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>JOHN R. SMITH, Sr.</b>   |  |   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>02-05-82</b>  |  |  |  |
| 3. SEX<br><b>MALE</b>   |  | 4. RACE<br><b>WHITE</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>02 16 32</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>49</b> YRS.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>North Charles General Hospital</b> |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Truck Driver-- Balto. Auction &amp; Supply Co.</b>                                      |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13a. STATE<br><b>Maryland</b>   |  | 13b. COUNTY<br><b>---</b>   |  | 13c. CITY OR TOWN<br><b>Baltimore</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Sidney Smith</b>   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Lillian Kline</b>   |  | 13e. STREET ADDRESS<br><b>115 W. Ostend Street 21230</b>  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><b>NO</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>212-28-0713</b>  |  | 17. INFORMANT ADDRESS<br><b>Mrs. Rose M. Smith 115 W. Ostend Street 21230</b>   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>MYOCARDIAL INFARCTION, MASSIVE</b><br><b>4100</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>02-04</b> 19 <b>82</b> , to <b>02-05</b> 19 <b>82</b> , that (I) (we) lost saw the deceased alive on <b>02-03</b> 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                       |  |   |  |   |  |  |  |
| 22b. SIGNATURE<br><b>Cesar Gamboa</b> DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>  |  |   |  | 22c. DATE SIGNED<br><b>02-05-82</b>   |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>CESAR GAMBOA</b>  |  |   |  | 22e. ADDRESS<br><b>90 N. CHARLES GENERAL HOSPITAL</b>   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>2/9/82</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Cedar Hill Cemetery</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Anne Arundel Md.</b>  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Mc Cully Funeral Home of Brooklyn</b><br><b>237 C. Patapsco Avenue Balto., Md. 21225</b>   |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>FEB 10 1982</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Theresa J. [Signature]</b>  |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death and may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |   |  |  |  |  |  |
|--|--|--|--|---|--|--|--|--|--|
| 1- FOR STATE REGISTRAR   |  |  |  | REG. NO. 8204210  |  |  |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>TERRI K. SMITH  |  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>FEB 2, 1982  |  |  |  | 2b. HOUR<br>240 P.M.   |  |
| 3. SEX<br>Female   |  | 4. RACE<br>White   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>11 28 45  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>YRS.<br>36 years                                  |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Washington D.C.   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.                           |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>University of MD Cancer Center |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Housewife           |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13a. STATE<br>West Va.   |  |  |  | 13b. COUNTY   |  | 13c. CITY OR TOWN<br>Capon Bridge  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Coulis   |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Elizabeth Sales  |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>NO  |  |  |  | 16b. SOCIAL SECURITY NO.<br>226-649643  |  | 17. INFORMANT<br>Walter C Smith Box 40 A Dillon Run Rd                               |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Upper Gastro Intestinal Bleeding<br>1729<br>DUE TO, OR AS A CONSEQUENCE OF (b) Metastatic Malignant Melanoma<br>DUE TO, OR AS A CONSEQUENCE OF (c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>5 days<br>5 years |  |  |  |   |  |  |  |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a   |  |  |  |   |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>      |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 1/14/82, 19 to 2/2/82, 19, that (I) (we) last saw the deceased alive on 2/2/82, 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |  |  |   |  |  |  |  |  |
| 22b. SIGNATURE<br>Halesh M. Patel M.D.   |  |  |  | DEGREE  |  | 22c. DATE SIGNED<br>2/2/82   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>HALESH M. PATEL, M.D.   |  |  |  | 22e. ADDRESS<br>UNIVERSITY OF MARYLAND HOSPITAL<br>BALTIMORE, MARYLAND 21201  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Cremation   |  | 23b. DATE<br>Feb 3, 1982   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Westview  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Catonsville, Balto, Maryland           |  |  |  |
| 24. FUNERAL DIRECTOR<br>Harry H Witzke 4112 Columbia Rd  |  |  |  | 25. ELICOTT CITY  |  | 25a. DATE REC'D. BY REGISTRAR<br>FEB 9 1982  |  |  |  |



STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 4 2 1 1

REG. NO.

1. FOR  
STATE  
REGISTRAR

|  |  |   |  |   |   |   |  |
|--|--|---|--|---|---|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>Wallace F. Smith   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>2 28 82 |   |   | 2b. HOUR<br>5 30 P M  |  |
| 3. SEX<br>male   |  | 4. RACE<br>Black  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>6 15 1927   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>54   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>BALTO Md  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U. S. A.  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.                                      |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Provident Hospital |  |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>DATA Proc. Mng.             |  |
| 13a. STATE<br>Md.  |  | 13b. COUNTY   |  | 13c. CITY OR TOWN<br>BALTO  |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Wallace F. Smith   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Justine Smith  |  | 13e. STREET ADDRESS<br>500 W. University Pkwy   |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>Yes  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>WWII   |  | 17. INFORMANT<br>Joseph Smith   |   | ADDRESS<br>4611 Old Court Rd  |  |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardiovascular Arrest</u><br>1850<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Metastatic disease.</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>Cancer of the Prostate</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |   |  |   |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |   |  |   |   |   |  |
| 19a. DATE OF OPERATION<br>7/8/81   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br>Ca of Prostate  |  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |   |   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |   |  |
| 22a. I certify that (1) (this hospital) attended the deceased from <u>2/28</u> 19 <u>82</u> , to <u>2/28</u> 19 <u>82</u> , that (1) (we) last saw the deceased alive on <u>2/28</u> 19 <u>82</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) (did not) view the body after death.   |  |   |  |   |   |   |  |
| 22b. SIGNATURE<br>Ronald D. Miles, M.D.  |  |   |  | DEGREE<br>M.D. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>   |   | 22c. DATE SIGNED<br>2/28/82   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Ronald D. Miles, M.D.   |  |   |  | 22e. ADDRESS<br>Provident Hosp.   |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>CREMATION  |  | 23b. DATE<br>3-5-82   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Westview  |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>CATONSVILLE Md.                                   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>James H. Morris & Sons 1701 E. Baltimore   |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br>MAR 3 - 1982   |   | 25b. REGISTRAR'S SIGNATURE<br>James Van Nuthen  |  |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the health department after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

Dear Sir,

I am writing to you regarding the matter of the...

Yours faithfully,



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 4 2 1 2

REG. NO.

|   |  |  |  |   |  |   |  |
|---|--|--|--|---|--|---|--|
| 1. FOR<br>STATE<br>REGISTRAR  |  | 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Booker T Snipe</b>  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>Feb. 26, 1982</b>   |  | 2b. HOUR<br><b>1:22 PM</b>  |  |
| 3. SEX<br><b>Male</b>   |  | 4. RACE<br><b>Black</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>2 7 23</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>58</b> YRS.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>S.C.</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Union Memorial Hosp.</b> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| 13a. STATE<br><b>MD</b>   |  | 13b. COUNTY  |  | 13c. CITY OR TOWN<br><b>Baltimore</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                               |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Charlie Snipe</b>  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Elsie Bostick</b>  |  | 13e. STREET ADDRESS<br><b>5509 Lothian Road</b>   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>Yes</b>  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>249-30-5646</b>  |  | 17. INFORMANT<br>ADDRESS<br><b>Martha L. Snipe 5509 Lothian Rd.</b>   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiac Arrest</b><br><b>4254</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Cardiomyopathy</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)  |  |  |  |   |  |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br><b>20 min.</b><br><b>8 yrs.</b> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |  |  |   |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |
| 22a. I certify that (I) <del>has</del> <b>did</b> attended the deceased from <b>Dec 22nd</b> 19 <b>82</b> , to <b>Feb 26</b> 19 <b>82</b> , that (I) <del>was</del> <b>lost</b> saw the deceased alive on <b>22nd</b> 19 <b>82</b> and that in (my) <del>last</del> <b>last</b> opinion death occurred on the date and hour and from the causes stated above, (I) <del>do</del> <b>did</b> view the body after death. |  |  |  |   |  |   |  |
| 22b. SIGNATURE<br><b>Alan B Cohen</b>   |  |  |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>        |  | 22c. DATE SIGNED<br><b>2/22/82</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Alan B. Cohen</b>   |  |  |  | 22e. ADDRESS<br><b>201 E. Univ. Parkway<br/>Bilto Md 21218</b>  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>3/3/82</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Cedar Hill Cem</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>A nne Arundel Co. MD</b>   |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Wm. C. March F/H 1101 E. North Ave.</b>  |  |  |  | 25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE<br><b>MAR 1 1982</b> <b>Frances Jan Nathan</b>   |  |   |  |

24.

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH   |                      |  |   |   |   |   |  |   |  | REG. NO. 04213 |  |
|---|----------------------|--|---|---|---|---|--|---|--|----------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>HARRY HARRY SNYDER</b>   |                      |  |   |   |   | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> ESTIMATED <input type="checkbox"/> <b>2-19-82</b> |  | 2b. HOUR <b>2:38P</b>   |  |                |  |
| 3. SEX <b>male</b>  | 4. RACE <b>white</b> | 5. DATE OF BIRTH<br>MONTH <b>7</b> DAY <b>21</b> YEAR <b>07</b>  | 6. AGE (IN YEARS)<br>LAST BIRTHDAY <b>74</b> YRS.                 | IF UNDER 1 YR.<br>MONTHS <b></b> DAYS <b></b>   | IF UNDER 24 HRS.<br>HOURS <b></b> MIN <b></b>                                 | 7c. DATE PRONOUNCED DEAD <b>2-19-82</b>   |  | 2d. HOUR <b>2:38P</b>   |  |                |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Pa.</b>  |                      | 7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>   |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b>  |  |   |  |                |  |
| 10. CITY OR TOWN OF DEATH <b>Baltimore</b>  |                      | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>1027 Bristol Place</b> |   |   |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Pipefitter</b>                               |  | 12b. KIND OF BUSINESS OR INDUSTRY <b>City Gov't</b>                                 |  |                |  |
| 13a. STATE <b>Md.</b>   |                      | 13b. COUNTY <b>Balto.</b>  |   | 13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO  |   | 13e. STREET ADDRESS <b>1027 Bristol Place</b>   |  |   |  |                |  |
| 14. FATHER'S NAME<br>FIRST <b>Frank</b> MIDDLE <b></b> LAST <b>Snyder</b>   |                      |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>Mary</b> MIDDLE <b></b> LAST <b>Kuhns</b>  |   |   |  |   |  |                |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN) <b>No</b>   |                      | (IF YES, GIVE WAR OR DATES) <b></b>  |   | 16b. SOCIAL SECURITY NO. <b>186-03-0675</b>   |   | 17. INFORMANT <b>Helen Snyder</b>   |  | ADDRESS <b>Balto., Md.</b>  |  |                |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br><b>4292</b> IMMEDIATE CAUSE (a) <b>Arteriosclerotic cardiovascular disease</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.<br>(b) <b></b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b></b>   |                      |  |   |   |   |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |                |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):   |                      |  |   |   |   |   |  |   |  |                |  |
| 19a. DATE OF OPERATION  |                      |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                 |   |   |   |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |                |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |                      |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b> |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |   |  |   |  |                |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |                      |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)       |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                             |   |  |   |  |                |  |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . |                      |  |   |   |   |   |  |   |  |                |  |
| ACTUAL SIGNATURE <b>Margarita A. Korell</b>   |                      |  | TITLE (SPECIFY) <b>M.D. Assistant</b> MEDICAL EXAMINER            |   |   |   |  | DATE SIGNED <b>2-19-82</b>  |  |                |  |
| EXAMINER'S NAME (TYPE OR PRINT) <b>Margarita A. Korell, M.D.</b>  |                      |  | ADDRESS <b>111 Penn Street</b>                                    |   |   |   |  |   |  |                |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Removal</b>  |                      |  | 23b. DATE <b>2/19/82</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY  |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE       |   |  |                |  |
| 24. FUNERAL DIRECTOR<br>NAME <b>Anatomy Board</b> ADDRESS <b>Balto., Md.</b>  |                      |  |   |   | 25a. DATE REC'D. BY REGISTRAR <b>MAR 2 1982</b>                               |   | 25b. REGISTRAR'S SIGNATURE <b>James J. North</b> |   |  |                |  |

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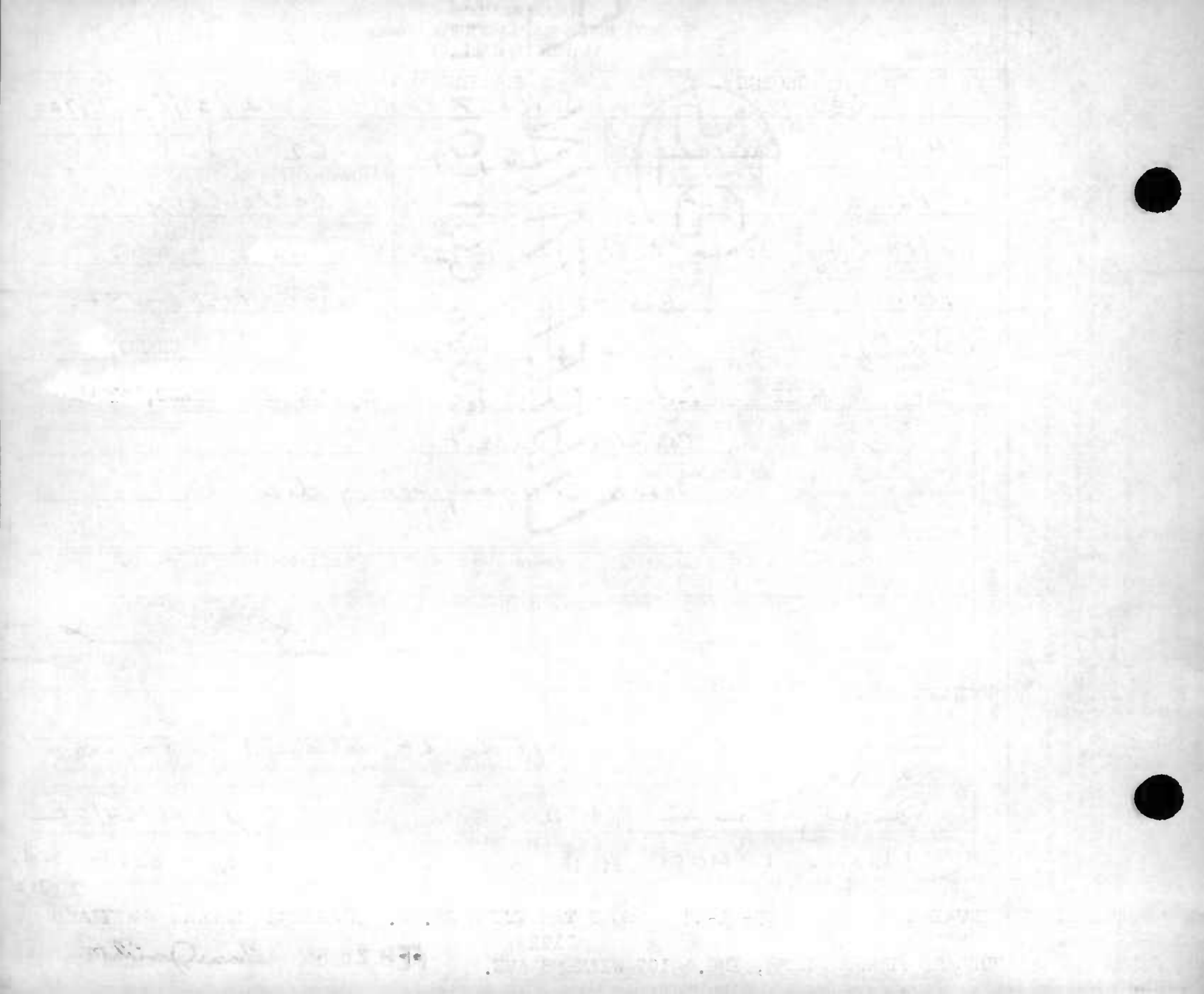
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the Department of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  | REG. NO. 8204214   |  |  |  |
|---|--|--|--|--|--|--|--|
| 1. FOR STATE REGISTRAR  |  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR 2/24/82   |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST George SOUCHAK   |  |  |  | 2b. HOUR 7:17 PM   |  |  |  |
| 3. SEX Male   |  | 4. RACE Caucasian  |  | 5. DATE OF BIRTH MONTH DAY YEAR 3/6/19   |  | 6. AGE (IN YEARS LAST BIRTHDAY) 62 YRS.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pa.   |  | 7b. CITIZEN OF WHAT COUNTRY? USA   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH Balto. City MD.   |  |
| 10. CITY OR TOWN OF DEATH Balto. City   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) South Balto. Gen. Hosp. |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) WAREHOUSEMAN   |  | 12b. KIND OF BUSINESS OR INDUSTRY A & P  |  |
| 13a. STATE Md.  |  | 13b. COUNTY -  |  | 13c. CITY OR TOWN Balto.   |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                       |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST Cornelius Souchak   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Vera UNKNOWN  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES WW II  |  |  |  |
| 16b. SOCIAL SECURITY NO. 217-05-4729  |  | 17. INFORMANT ADDRESS ANN SOUCHAK 4395 PARKTON STREET, 21229   |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac arrest 4149                                   |  |  |  |  |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF (b) Severe coronary artery disease   |  |  |  |  |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF (c)  |  |  |  |  |  |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                              |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)   |  |  |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a. I certify that (this hospital) attended the deceased from 2/4, 19 82, to 2/4, 19 82, that (we) lost the deceased alive on above, (we) (did) not view the body after death. |  |  |  |  |  |  |  |
| 22b. SIGNATURE Janice I. Masi, M.D.   |  |  |  | DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>        |  | 22c. DATE SIGNED 2/24/82   |  |
| 22a. PHYSICIAN'S NAME (TYPE OR PRINT) Janice I. Masi, M.D.  |  |  |  | 22e. ADDRESS 3001 S. Hanover St. Balto. Md. 21229  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL  |  | 23b. DATE 03-01-82   |  | 23c. NAME OF CEMETERY OR CREMATORY HOLY TRINITY RUSS. OR.  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE ELK RIDGE HOWARD MARYLAND  |  |
| 24. FUNERAL DIRECTOR NAME ADDRESS HUBBARD FUNERAL HOME, INC. 4107 WILKENS AVE. 21229  |  |  |  | 25a. DATE REC'D. BY REGISTRAR FEB 26 1982  |  | 25b. REGISTRAR'S SIGNATURE   |  |



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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at birth.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |   |  |   |  |   |                            | 8 2 0 4 2 1 5  |  |
|--|--|--|--|---|--|---|--|---|----------------------------|--|--|
| FOR<br>1 - STATE<br>REGISTRAR  |  |  |  |   |  |   |  |   |                            | REG. NO.   |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>ALBERT L. SPAHN</b>   |  |  |  |   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>02/05/82</b> |   | 2b. HOUR<br><b>2:42 PM</b> |  |  |
| 3. SEX<br><b>Male</b>  |  | 4. RACE<br><b>White</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>11 8 10</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>71</b> YRS.   |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.          |                            |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.                               |  |   |                            |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTO. CITY</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>ST. AGNES HOSPITAL</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Grocer</b>               |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Grocer Store</b>                  |                            |  |  |
| 13a. STATE<br><b>Maryland</b>  |  | 13b. COUNTY  |  | 13c. CITY OR TOWN<br><b>Baltimore</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>3101 Strickland Street 21229</b>                |                            |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Anton Spahn</b>   |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Catherine Heinmuller</b>  |  |   |  |   |                            |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>NO</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>217-07-3263</b>   |  | 17. INFORMANT<br><b>Evelyn I. Spahn</b>   |  | ADDRESS<br><b>3101 Strickland Street</b>  |  | <b>21229</b>  |                            |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARDIAC STANDSTILL WITH RECENT</b><br><b>0389</b><br>DUE TO, OR AS A CONSEQUENCE OF <b>ACUTE MYOCARDIAL INFARCTION,</b><br>(b) <b>SEPTICEMIA, ELECTROLYTE IMBALANCE</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>LATENT ACIDOSIS</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. |  |  |  |   |  |   |  |   |                            | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |  |  |   |  |   |  |   |                            |  |  |
| 19a. DATE OF OPERATION   |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                            | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)                   |  |   |                            |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |  |  | 21e. PLACE OF INJURY<br>(AT HOME STREET FACTORY OFFICE FARM ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |                            |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>1/24</b> , 19 <b>82</b> , to <b>2/5</b> , 19 <b>82</b> , that (I) (we) lost saw the deceased alive on <b>2/5</b> , 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |  |  |   |  |   |  |   |                            |  |  |
| 22b. SIGNATURE<br><b>Arthur J. Hutter</b><br>DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>   |  |  |  |   |  | 22c. DATE SIGNED  |  |   |                            |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Arthur J. Hutter</b>   |  |  |  |   |  | 22e. ADDRESS  |  |   |                            |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |  |  |  | 23b. DATE<br><b>2/8/82</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Loudon Park Cemetery</b>                               |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Maryland</b>   |                            |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Hubbard Funeral Home, Inc.</b>  |  |  |  |   |  | ADDRESS<br><b>4107 Wilkens Ave.</b>   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>FEB 8 1982</b>                        |                            | 25b. REGISTRAR'S SIGNATURE<br><b>Charles J. Hutter</b>   |  |





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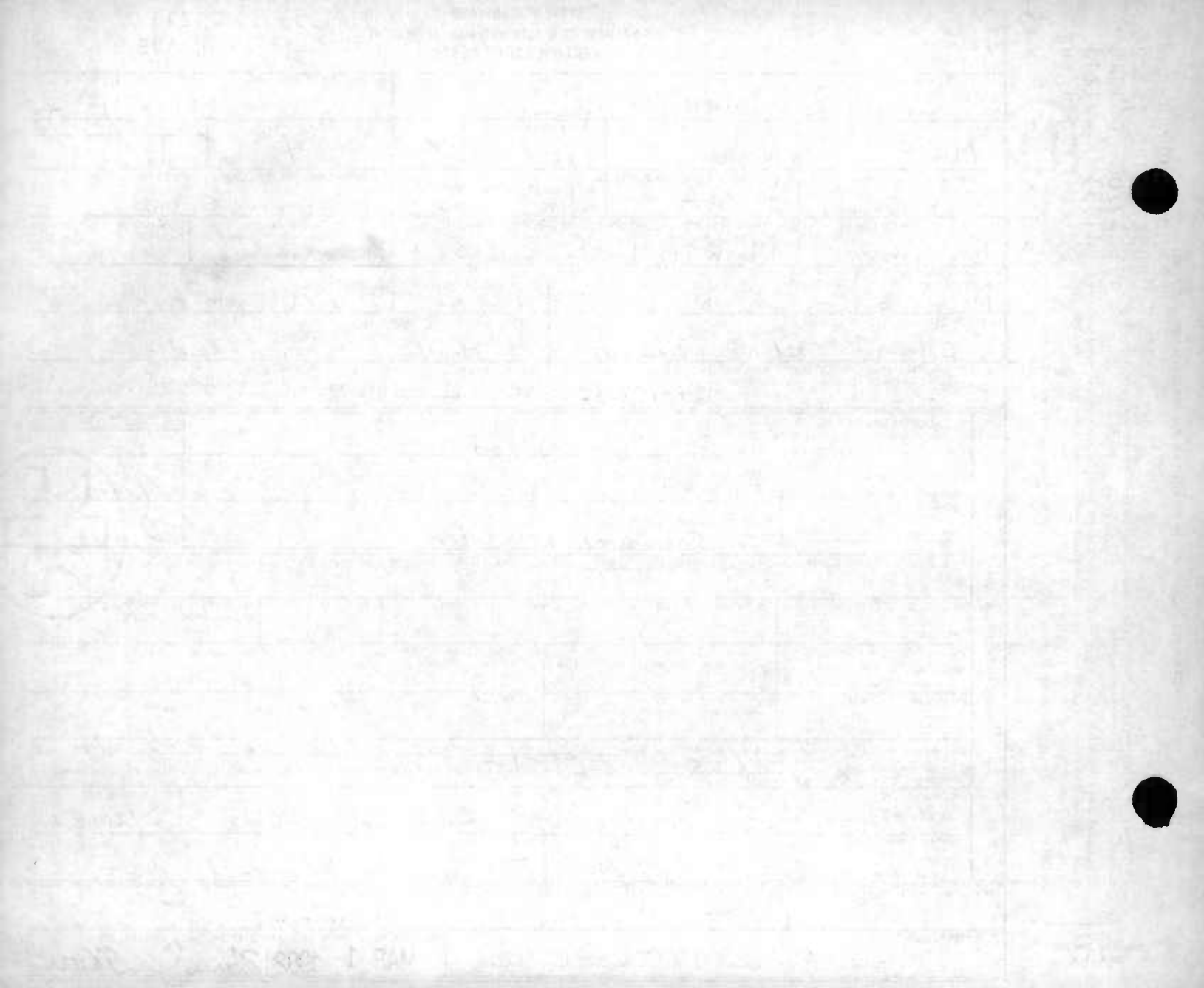
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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of same.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  |  | REG. NO. 82 04217  |  |  |   |  |
|---|--|---|--|--|--|--|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br><b>DOROTHY SPECTOR</b>  |  |   |  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>2 10 82</b>               |  |  | 2b. HOUR<br><b>2-28a.m</b>  |  |
| 3. SEX<br><b>FEMALE</b>   |  | 4. RACE<br><b>CAUCASIAN</b>   |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>1 12 1913</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS HOURS MIN.<br><b>69 YRS</b>                      |  | IF UNDER 1 YEAR IF UNDER 24 HRS.  |  |
| 7. BIRTHPLACE (COUNTRY)<br><b>MARYLAND</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>CITY</b>  |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>SINAI HOSPITAL</b> |  |  |  | 12. HOUSEWIFE (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>HOUSEWIFE</b>                    |  | 12b. BUSINESS OR INDUSTRY<br><b>TYPE</b>  |  |
| 13a. STATE<br><b>MD.</b>  |  | 13b. COUNTY<br><b>BALTO.</b>  |  | 13c. CITY OR TOWN<br><b>BALTO.</b>   |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>3607 TULSA RD. 21207</b>  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>MAX BERNSTEIN</b>   |  |   |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>ADA UNKNOWN</b> |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><b>NO</b>  |  | 16b. (IF YES, GIVE WAR OR DATES)<br><b>1916-1918</b>  |  | 17. INFORMANT ADDRESS<br><b>MR. HERMAN SPECTOR 3607 TULSA RD. BALTO., MD 21207</b>   |  |  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>ASPIRATION PNEUMONIA</b><br><b>1749</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) <b>CARCINOMA BREAST &amp; WIDESPREAD METASTASIS</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>READ METASTASIS</b> |  |   |  |  |  |  |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)   |  |   |  |  |  |  |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)  |  |  |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |  |  |   |  |
| 22a. I certify that (a) (this hospital) attended the deceased from <b>1/28/82</b> , 19 <b>82</b> , to <b>2/10/82</b> , 19 <b>82</b> that (b) (we) lost saw the deceased expire on <b>2/10/82</b> , 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.  |  |   |  |  |  |  |  |   |  |
| 22b. SIGNATURE<br><b>Sheila Ebenezer</b><br>M.D.  |  |   |  | DEGREE<br><b>M.D.</b>  |  |  |  | 22c. DATE SIGNED<br><b>2/10/82</b>  |  |
| 22d. PHYSICIAN'S STREET ADDRESS (TYPE OR PRINT)<br><b>SHEILA EBENEZER</b>   |  |   |  | 22e. ADDRESS<br><b>SINAI HOSPITAL OF BALTO., MD</b>  |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>BURIAL</b>  |  | 23b. DATE<br><b>FEB. 12, 1982</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>MOSES MONTEFIORE WOODMOOR HEBREW CONG.</b>  |  | 23d. LOCATION<br><b>BALTIMORE</b>  |  | COUNTY<br><b>MARYLAND</b>   |  |
| 24. FUNERAL DIRECTOR<br>NAME <b>SOL LEVINSON &amp; BROS., INC.</b><br>ADDRESS <b>6010 REISTERSTOWN RD. BALTO., MD 21215</b>   |  |   |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>FEB 17 1982</b>  |  |   |  |
| 25b. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>  |  |   |  |  |  |  |  |   |  |

UNITED STATES DEPARTMENT OF JUSTICE  
FEDERAL BUREAU OF INVESTIGATION

TO : SAC, NEW YORK  
FROM : SAC, NEW YORK  
SUBJECT: [Illegible]  
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RECEIVED  
FEB 11 1964

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MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  | REG. NO. 82 04218   |  |   |  |
|---|--|---|--|---|--|---|--|
| 1. FOR STATE REGISTRAR  |  |   |  |   |  |   |  |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br><b>Dorothy (Dorothy) Spence</b>   |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR 2b. HOUR<br><b>02 15 82 2:25 AM</b>  |  |   |  |
| 3. SEX<br><b>Female</b>   |  | 4. RACE<br><b>Black</b>   |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>04 20 14</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY) YRS MONTHS DAYS<br><b>67</b>  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Baltimore, Md.</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore City</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Mercy Hospital</b> |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST WORKING LIFE)<br><b>Homemaker</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| 13a. STATE<br><b>Md</b>   |  |   |  | 13b. COUNTY<br><b>Baltimore</b>   |  | 13c. STREET ADDRESS<br><b>1 W. Conway St., Baltimore, Md 21201</b>  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>Charles West</b>  |  |   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Vi Ola Camphor</b>   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> IF UNKNOWN) (IF YES, GIVE WAR OR DATES)   |  |   |  | 16b. SOCIAL SECURITY NO.<br><b>214-01-1355</b>  |  | 17. INFORMANT ADDRESS<br><b>Walter Thomas 639 Melvin Dr.</b>  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiac Arrest</b><br><b>4275</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |  |   |  |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)<br><b>Intracerebral Hematoma</b>   |  |   |  |   |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>11 24 82</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>2/19</b> 19 <b>82</b> , saw the deceased alive on <b>2/19</b> 19 <b>82</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |   |  |   |  |   |  |
| 22b. SIGNATURE<br><b>Neal M. Friedlander, M.D.</b>  |  |   |  | DEGREE<br><b>M.D.</b>   |  | 22c. DATE SIGNED<br><b>2/15/82</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Neal M. Friedlander, M.D.</b>   |  |   |  | 22e. ADDRESS<br><b>Mercy Hospital 301 St. Paul St., Baltimore, Md 21202</b>   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>2/19/82</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Arbutus Mem. Pk.</b>   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>Baltimore Co. MD</b>  |  |
| 24. FUNERAL DIRECTOR NAME<br><b>Wm. C. March F/H</b>  |  |   |  | ADDRESS<br><b>1101 E. North Ave.</b>  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>FEB 16 1982</b>   |  |



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Revised

Donation (10/10)

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| Balance | 10/10 | 10/10 | 10/10 | 10/10 |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

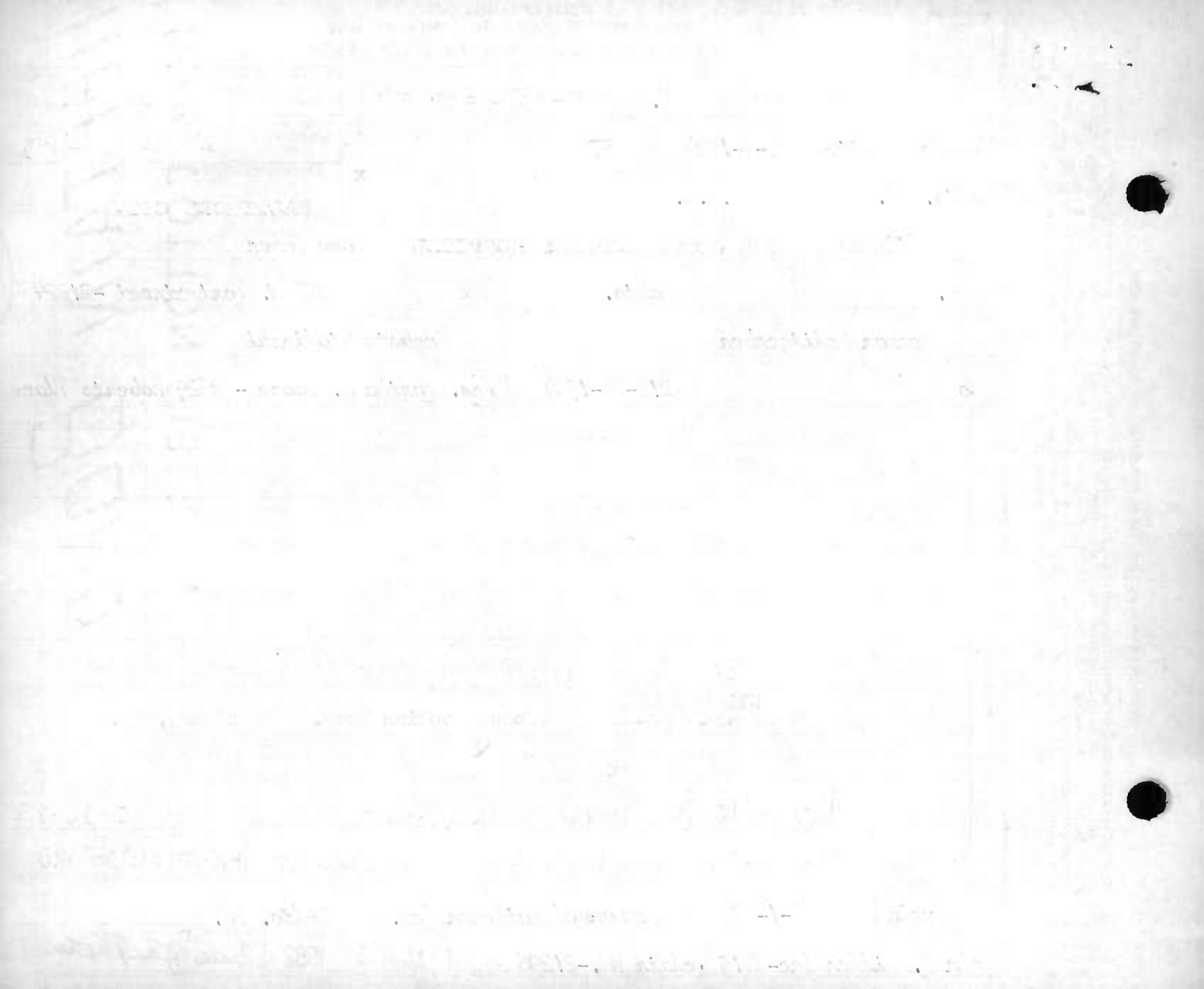
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |   |  |   |  |  |  |
|--|--|--|--|---|--|---|--|--|--|
| 1. FOR STATE REGISTRAR   |  | REG. NO. 8 2 0 4 2 1 9   |  |   |  |   |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>FRANK D. SPENCER</b>  |  |  |  |   |  | 2a. DATE OF DEATH<br>MONTH <b>2</b> DAY <b>24</b> YEAR <b>82</b>                                |  | 2b. HOUR<br><b>4:55</b> P.M.   |  |
| 3. SEX<br><b>MALE</b>  |  | 4. RACE<br><b>BLACK</b>  |  | 5. DATE OF BIRTH<br>MONTH <b>6</b> DAY <b>11</b> YEAR <b>03</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>78</b> YRS.   |  | 7. IF UNDER 1 YEAR<br>MONTHS <b>0</b> DAYS <b>0</b> HOURS <b>0</b> MIN.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Beauford, North Car.</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>(USA)</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.                               |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Balto.</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Sinai Hospital</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)                                |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |  |  |   |  |   |  |  |  |
| 13a. STATE<br><b>Md.</b>   |  | 13b. COUNTY  |  | 13c. CITY OR TOWN<br><b>Balto.</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>3101 Carlisle Ave.</b>   |  |
| 14. FATHER'S NAME<br>FIRST <b>Joney</b> MIDDLE <b>C.</b> LAST <b>Spencer</b>   |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>Martha</b> MIDDLE <b>Spencer</b> LAST <b>Jones</b>   |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>No</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>215-18-6403</b>   |  | 17. INFORMANT ADDRESS<br><b>Katherine Spencer 3101 Carlisle Ave</b>   |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>metastatic CA of Prostate</b><br><b>1850</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |  |  |   |  |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)  |  |  |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |  |  |
| 22a. I certify that (I) this hospital attended the deceased from <b>1/9</b> 19 <b>82</b> , to <b>2/24</b> 19 <b>82</b> , that (I) (we) lost saw the deceased alive on <b>1/9</b> 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.                         |  |  |  |   |  |   |  |  |  |
| 22b. SIGNATURE<br><b>Claudio Levin</b> DEGREE  |  |  |  |   |  | 22c. DATE SIGNED<br><b>2/24/82</b>  |  | 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Claudio Levin</b>  |  |
| 22e. ADDRESS<br><b>Sinai Hospital</b>  |  |  |  |   |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>3/1/82</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>KING MEM. PARK</b>   |  | 23d. LOCATION<br>CITY OR TOWN <b>BALTO., MD.</b> COUNTY STATE                                   |  |  |  |
| 24. FUNERAL DIRECTOR<br><b>LEROY O. DYETT &amp; SON FUNERAL HOME 4600 LIBERTY</b>  |  |  |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>FEB 25 1982</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>James J. [Signature]</b>  |  |

1987 23 FEB

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED IN THE DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |                      |   |                             |  |                             |  |  |  |  | REG. NO. 04220 |  |
|--|----------------------|---|-----------------------------|--|-----------------------------|--|--|--|--|----------------|--|
| 1. DECEASED NAME (TYPE OR PRINT) <b>DOROTHY V. SPLITGERBER</b>   |                      |   |                             |  |                             | 2a. DATE KNOWN OF DEATH <b>2 26 19 82</b>  |  | 2b. HOUR <b>AM</b>                                   |  |                |  |
| 3. SEX <b>Female</b>   | 4. RACE <b>White</b> | 5. DATE OF BIRTH <b>9-7-1924</b>  | 6. AGE (IN YEARS) <b>57</b> | IF UNDER 1 YR. MONTHS DAYS   | IF UNDER 24 HRS. HOURS MIN. | 7c. DATE PRONOUNCED DEAD <b>2-26 19 82</b>   |  | 7d. HOUR <b>103 AM</b>                               |  |                |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Balto. Md.</b>  |                      | 7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>  |                             | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                             | 9. <b>BALTIMORE CITY</b> OR COUNTY OF DEATH <b>BALTIMORE CITY MD.</b>                        |  |  |  |                |  |
| 10. CITY OR TOWN OF DEATH <b>Baltimore</b>   |                      | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>THE JOHNS HOPKINS HOSPITAL</b> |                             |  |                             | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Home Maker</b>              |  | 12b. KIND OF BUSINESS OR INDUSTRY                    |  |                |  |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |                      |   |                             |  |                             |  |  |  |  |                |  |
| 13a. STATE <b>Md.</b>  |                      | 13b. COUNTY <b>Balto.</b>   |                             | 13c. CITY OR TOWN <b>Balto.</b>  |                             | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS <b>207 N. Port Street -21224</b> |  |                |  |
| 14. FATHER'S NAME <b>Herman Splitgerber</b>  |                      |   |                             |  |                             | 15. MOTHER'S MAIDEN NAME <b>Augusta Stolinski</b>  |  |  |  |                |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>No</b>   |                      | 16b. SOCIAL SECURITY NO. <b>212-22-1534</b>   |                             | 17. INFORMANT ADDRESS <b>Mrs. Martha B. Moore - 3629 Roberts Place</b>   |                             |  |  |  |  |                |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY: <b>Strangulation</b><br><b>9139</b> IMMEDIATE CAUSE (a) <b>9139</b><br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last:<br>(b) <b>Seizure disorder and mental retardation</b><br>(c) <b>Seizure disorder and mental retardation</b><br>PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).<br><b>Seizure disorder and mental retardation</b> |                      |   |                             |  |                             |  |  |  |  |                |  |
| 19a. DATE OF OPERATION   |                      | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |                             |  |                             | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>             |  |  |  |                |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |                      | 21b. TIME OF INJURY <b>2 P.M. 2-26 19 82</b>  |                             | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <b>Found on floor with restraint on neck</b>                               |                             |  |  |  |  |                |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>  |                      | 21e. PLACE OF INJURY (AT HOME, IN STREET, FACTORY, PARK, ETC.) <b>HOSPITAL</b>  |                             | 21f. LOCATION <b>Johns Hopkins Hosp. Baltimore, Md.</b>  |                             |  |  |  |  |                |  |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .  |                      |   |                             |  |                             |  |  |  |  |                |  |
| ACTUAL SIGNATURE <b>Monique One Yshell</b>   |                      | TITLE (SPECIFY) <b>M.D. ASSISTANT</b>   |                             |  |                             | DATE SIGNED <b>2-26-82</b>   |  |  |  |                |  |
| EXAMINER'S NAME (TYPE OR PRINT) <b>MAR GARITS AKA KOREU</b>  |                      | ADDRESS <b>111 PENN ST BALTIMORE MD</b>   |                             |  |                             |  |  |  |  |                |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>  |                      | 23b. DATE <b>3-1-82</b>   |                             | 23c. NAME OF CEMETERY OR CREMATORY <b>Immanuel Lutheran Cem.</b>   |                             | 23d. LOCATION (CITY OR TOWN) <b>Balto. Md.</b>   |  |  |  |                |  |
| 24. FUNERAL DIRECTOR NAME <b>John C. Miller Inc-6415 Belair Rd.-21206</b>  |                      | ADDRESS <b>6415 Belair Rd.-21206</b>  |                             | 25a. DATE REC'D. BY REGISTRAR <b>MAR 1 1982</b>  |                             | 25b. REGISTRAR'S SIGNATURE <b>Frances Jean Nathan</b>  |  |  |  |                |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR  
1. STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |   |   |  |   |
|---|--|---|---|--|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>GEORGE H. SPRAGUE</b>  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>2 28 82</b>                                   |  | 2b. HOUR<br>MIN.<br><b>2:25 A</b>                         |
| 3. SEX<br><b>MALE</b>   | 4. RACE<br><b>WHITE</b>  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>09 13 10</b>   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>71</b> YRS.  |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MARYLAND</b>  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.                        |   |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>ST. AGNES HOSPITAL</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>TRUCK DRIVER</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>MONARCH FOODS</b> |
| 13a. STATE<br><b>MARYLAND</b>   |  |   | 13b. COUNTY<br><b>---</b>   | 13c. CITY OR TOWN<br><b>BALTIMORE</b>  |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>GEORGE W. SPRAGUE</b>  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>DAISY PATTERSON</b>                 |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>YES WW II</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>216-05-5483</b>  |   | 17. INFORMANT<br>ADDRESS<br><b>BETTY L. SPRAGUE 401 LONG ISLAND AVENUE APT. #6 21229</b> |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiogenic Shock</b><br>4100<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Acute Myocardial Infarction</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |   |   |  |   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I:  |  |   |   |  |   |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                |   |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  |   |   |  |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)           |   |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>Feb. 27</b> , 19 <b>82</b> , to <b>Feb 28</b> , 19 <b>82</b> , that (I) (we) lost saw the deceased alive on <b>Feb. 28</b> , 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |   |   |  |   |
| 22b. SIGNATURE<br><b>Oscar Hernandez</b>  |  | DEGREE  |   | 22c. DATE SIGNED<br><b>2-28-82</b>   |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>OSCAR HERNANDEZ, M.D.</b>   |  | 22e. ADDRESS<br><b>ST. AGNES HOSPITAL, 900 S. CATON AVENUE</b>  |   |  |   |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>BURIAL</b>  |  | 23b. DATE<br><b>03-03-82</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>MEADOWRIDGE MEM. PK.</b>                        |   |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>ELK RIDGE HOWARD MARYLAND</b>  |  |   |   |  |   |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>HUBBARD FUNERAL HOME, INC.</b>   |  | ADDRESS<br><b>4107 WILKENS AVE.</b>   |   | 25a. DATE REC'D. BY REGISTRAR<br><b>MAR 3 1982</b>                                       |   |
| 25b. REGISTRAR<br><b>Charles J. Nathan</b>  |  |   |   |  |   |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |                                     |   |  |  | 8 2 0 4 2 2 2       |  |
|---|-------------------------------------|---|--|--|---------------------|--|
| 1. FOR STATE REGISTRAR  |                                     |   | REG. NO.   |  |                     |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br>George Spruill  |                                     |   | 2a. DATE OF DEATH<br>February 26 82                |  | 2b. HOUR<br>9:45 AM |  |
| 3. SEX<br>Male  | 4. RACE<br>Black                    | 5. DATE OF BIRTH<br>4 15 10   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>71 YRS.                                     |                     | 7. IF UNDER 1 YEAR<br>MONTHS DAYS  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>N.C.   | 7b. CITIZEN OF WHAT COUNTRY?<br>USA | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD                      |                     |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore  |                                     | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Providence Hosp.                                  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                  |                     | 12b. KIND OF BUSINESS OR INDUSTRY  |
| 13a. STATE<br>MO  |                                     |   | 13b. COUNTY  | 13c. CITY OR TOWN<br>Baltimore   |                     | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |
| 14. FATHER'S NAME<br>George Spruill   |                                     |   | 15. MOTHER'S MAIDEN NAME<br>Mary Lafayette Sq. N/H |  |                     |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>NO   |                                     | 16b. SOCIAL SECURITY NO.<br>N/A   |  | 17. INFORMANT ADDRESS<br>Rena Anderson 1624 Division St.                       |                     |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) 0389 Cardio - Respiratory Arrest<br>DUE TO, OR AS A CONSEQUENCE OF (b) Sepsis<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>DUE TO, OR AS A CONSEQUENCE OF (c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>48 hrs. |                                     |   |  |  |                     |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).   |                                     |   |  |  |                     |  |
| 19a. DATE OF OPERATION  |                                     | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>      |                     | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                                     | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 10, PART 1 OR PART 2) |                     |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |                                     | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |                     |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 2/16/82, 1982, to 2/26/82, 1982, that (I) (we) lost saw the deceased alive on 2/26/82, 1982, and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.   |                                     |   |  |  |                     |  |
| 22b. SIGNATURE<br>Robert R. Keut MD   |                                     |   |  | 22c. DATE SIGNED<br>2/26/82  |                     | 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Robert R. Keut  |
| 22e. ADDRESS<br>2600 Liberty Heights 21215  |                                     |   |  | 22f. ADDRESS   |                     |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial   |                                     | 23b. DATE<br>3/4/82   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Mt. Zion Cem.                            |                     | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore MD   |
| 24. FUNERAL DIRECTOR<br>NAME<br>Wm. C. March F/H 1101 E. North Ave.   |                                     |   |  | 25a. DATE REC'D. BY REGISTRAR<br>MAR 3 1982                                    |                     | 25b. REGISTRAR'S SIGNATURE<br>Frances VanWarthen   |



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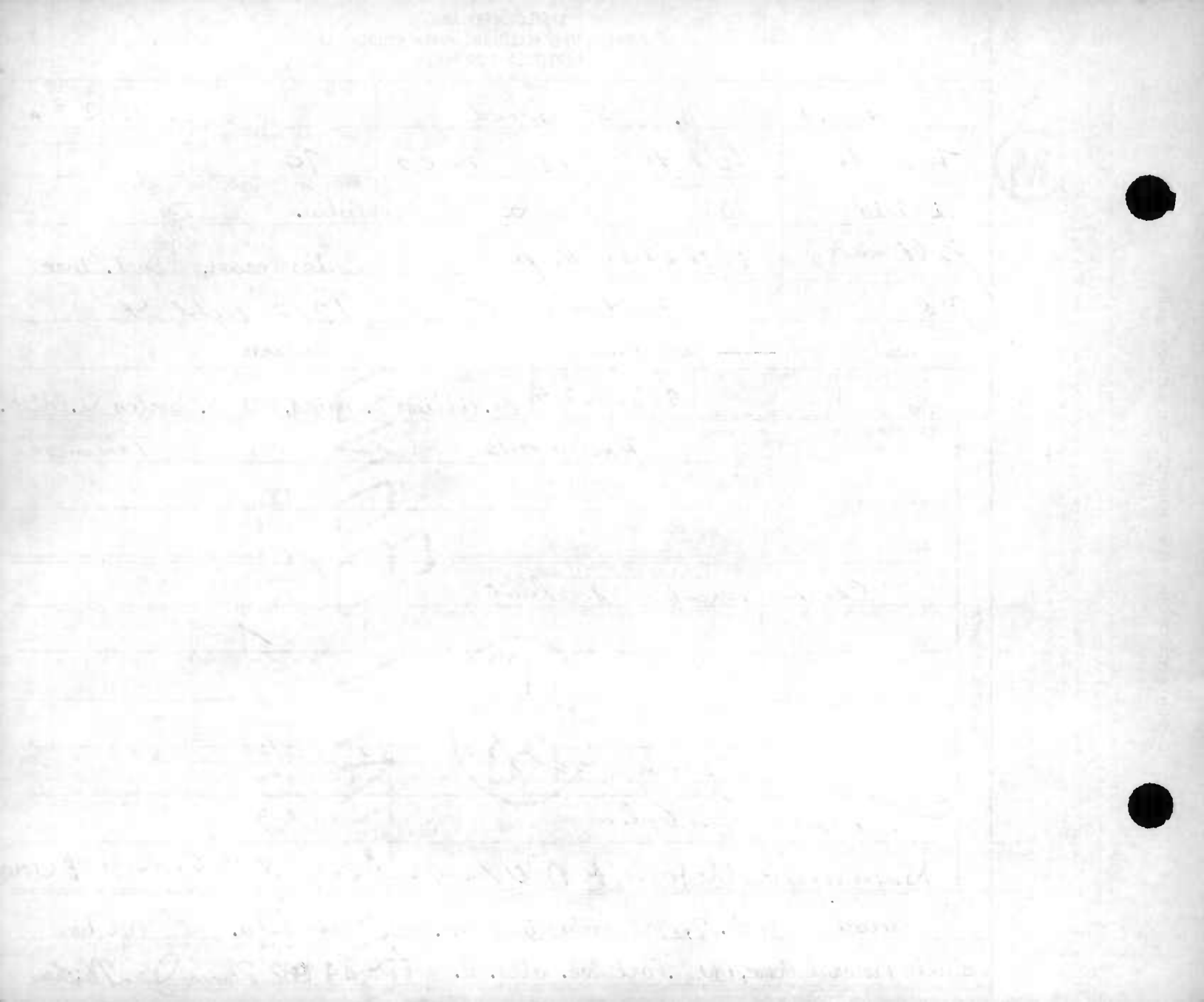
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.



| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  |   |  |   |  |  |   | REG. NO.  |  |
|--|--|---|--|---|--|---|--|--|---|---|--|
| 1. FOR STATE REGISTRAR   |  |   |  |   |  | 7 2 0 4 2 2 3   |  |  |   |   |  |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br><i>Mabel B. STANFORD</i>   |  |   |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><i>2-24-82</i>  |  |  |   | 2b. HOUR<br><i>2:30 AM</i>  |  |
| 3. SEX<br><i>Female</i>  |  | 4. RACE<br><i>White</i>   |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><i>12-14-02</i>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><i>79</i> YRS  |  | IF UNDER 1 YEAR MONTHS DAYS  |   | IF UNDER 24 HRS. HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><i>Virginia</i>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><i>USA</i>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><i>Balto. City</i> MD.  |  |  |   |   |  |
| 10. CITY OR TOWN OF DEATH<br><i>Baltimore</i>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><i>Lutheran Hosp.</i> |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><i>Sales Person,</i>   |  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><i>Dept. Store</i> |   |  |
| 13a. RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE<br><i>Md.</i>   |  |   |  | 13b. COUNTY<br><i>Baltimore</i>   |  | 13c. CITY OR TOWN<br><i>Baltimore</i>   |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   | 13e. STREET ADDRESS<br><i>1213 Light St.</i>  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><i>Paul Blackstone</i>  |  |   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><i>Unknown</i>  |  |   |  |  |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><i>No</i>   |  |   |  | 16b. SOCIAL SECURITY NO.<br><i>218036219</i>  |  | 17. INFORMANT ADDRESS<br><i>Mr. William J. Hagins, 1804 S. Charles St. Balto.</i>   |  |  |   |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Pneumonia</i><br>4860<br>DUE TO, OR AS A CONSEQUENCE OF (b) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) _____<br>DUE TO, OR AS A CONSEQUENCE OF (c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><i>1 month</i> |  |   |  |   |  |   |  |  |   |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><i>Cerebro-vascular Accident.</i>   |  |   |  |   |  |   |  |  |   |   |  |
| 19a. DATE OF OPERATION   |  |   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><i>2/23 82</i>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |   |   |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |  |   |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>2/23 82</i> to <i>2/24 82</i> , that (I) (we) lost saw the deceased alive on <i>2/23 82</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |   |  |   |  |   |  |  |   |   |  |
| 22b. SIGNATURE<br><i>Norman Goldstein</i>  |  |   |  |   |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  |  | 22c. DATE SIGNED  |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><i>Norman Goldstein, M.D.</i>   |  |   |  |   |  | 22e. ADDRESS<br><i>U. Mary Land Hosp 225 Green St Balto</i>   |  |  |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><i>Burial</i>   |  |   |  | 23b. DATE<br><i>Feb. 27, 1982</i>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><i>Meadowridge Mem. Park</i>  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><i>Howard Co. Maryland</i>                        |   |   |  |
| 24. FUNERAL DIRECTOR NAME<br><i>McUilly Funeral Home, 130 E. Fort Ave. Balto. Md.</i>  |  |   |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><i>FEB 24 1982</i>   |  |  |   |   |  |
|  |  |   |  |   |  | 25b. REGISTRAR'S SIGNATURE<br><i>Charles Jean Nathan</i>  |  |  |   |   |  |



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| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  |   |   |  |  |  |  |
|--|--|---|--|---|---|--|--|--|--|
| 1. FOR STATE REGISTRAR   |  |   |  |   | REG. NO.  |  |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br><b>ROBERT LEE STANTON</b>  |  |   |  |   | 2a. DATE OF DEATH<br>MONTH <b>2</b> DAY <b>15</b> YEAR <b>82</b>                                |  |  | 2b. HOUR<br><b>4</b> PM  |  |
| 3 SEX<br><b>MALE</b>   |  | 4 RACE<br><b>WHITE</b>  |  | 5. DATE OF BIRTH<br>MONTH <b>Jan</b> DAY <b>19</b> YEAR <b>1916</b>   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>66</b> YRS                                     |  | 7b. HOUR<br><b>4</b> PM  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Washington D.C.</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.                    |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>South Baltimore General Hospital</b> |  |   |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Plumber</b>      |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Construction</b>   |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE <b>Maryland</b> 13a. CITY <b>Annapolis</b> 13a. STREET <b>Arundel</b>   |  |   |  |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>4402 Ritchie Highway</b> |  |  |
| 14. FATHER'S NAME<br>FIRST <b>Norman</b> MIDDLE <b>E.</b> LAST <b>Stanton</b>  |  |   |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>Sadie</b> MIDDLE <b>E.</b> LAST <b>Berkley</b>             |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><b>No</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>578 16 5403</b>  |  | 17. INFORMANT<br><b>George H. Stanton</b> ADDRESS <b>8820 Tamar Dr Apt 201 Columbia, Md.</b>  |   |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Acute Myocardial Infarction</b><br>DUE TO, OR AS A CONSEQUENCE OF <b>Atherosclerosis Cardiovascular System</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>Chronic Renal Failure</b><br>DUE TO, OR AS A CONSEQUENCE OF |  |   |  |   |   |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |   |  |   |   |  |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |   |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>12-31</b> 19 <b>81</b> , to <b>2-15</b> 19 <b>82</b> , that (I) (we) lost<br>saw the deceased alive on <b>2-15</b> 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.   |  |   |  |   |   |  |  |  |  |
| 22b. SIGNATURE<br><b>Stephen Alphon</b>  |  |   |  | DEGREE <b>MD</b><br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>    |   | 22c. DATE SIGNED<br><b>2/15/82</b>   |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Stephen Alphon</b>   |  |   |  | 22e. ADDRESS<br><b>SBGH Baltimore, Md.</b>  |   |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>2/18/82</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Cedar Hill Cemetery</b>  |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Suitland P.G. Maryland</b>          |  | 23e. DATE REC'D. BY REGISTRAR<br><b>FEB 19 1982</b>  |  |
| 24. FUNERAL DIRECTOR<br><b>Francis Gasch's Sons Funeral Home, P.A.</b><br><b>Hyattsville, Maryland</b>   |  |   |  |   | 25a. DATE REC'D. BY REGISTRAR<br><b>FEB 19 1982</b>   |  |  |  |  |

BP

Initial 2/19/82  
Francis Gresh's Sons' Mineral House, P.A.  
Hartsville, Maryland  
Cedar Hill Cemetery  
Suitland, P.D. Maryland

1/15/82

1/15/82

Chondromel Folios

Francis Gresh's Sons' Mineral House

1/15/82

1/15/82

1/15/82

1/15/82

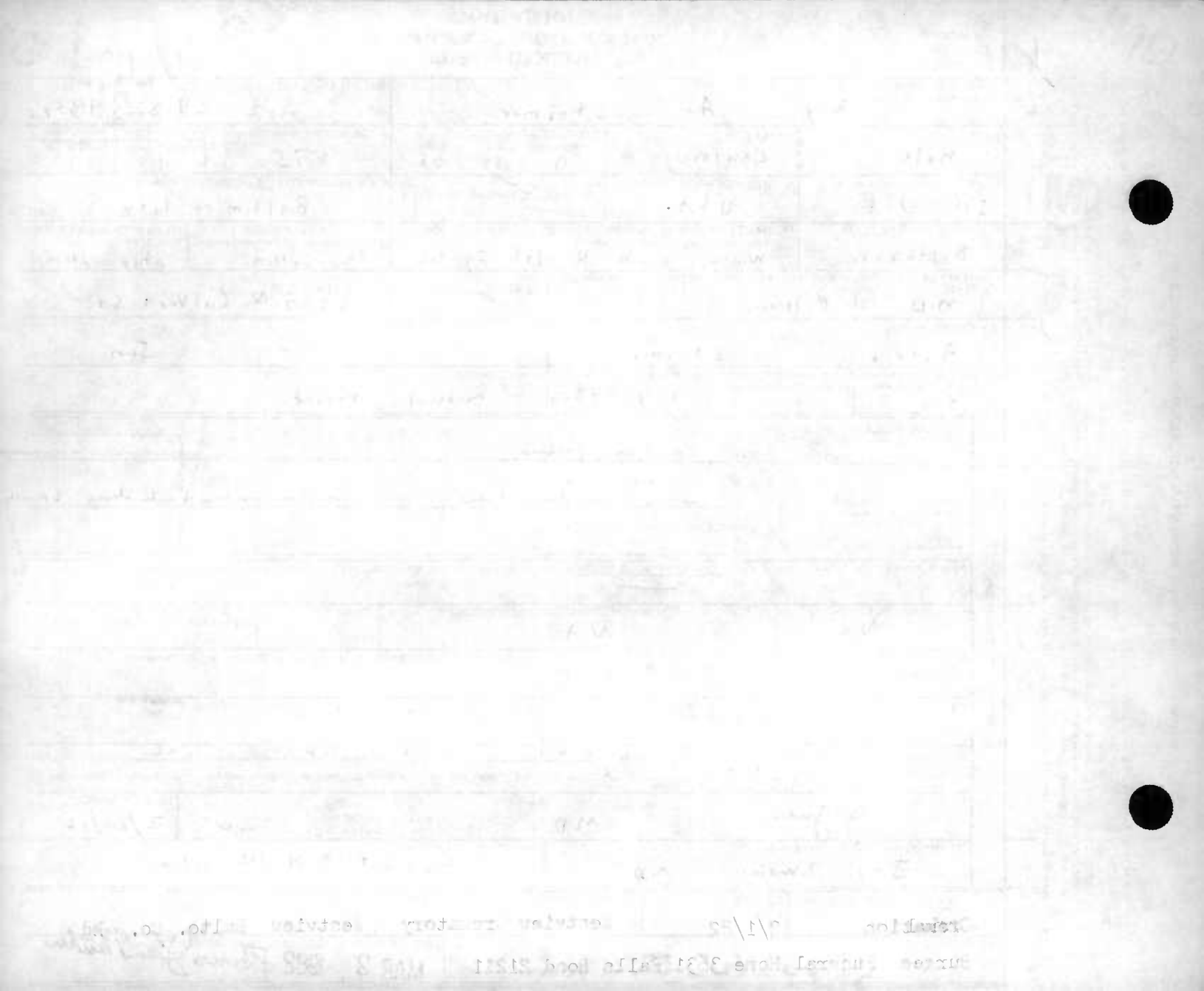
1/15/82

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## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  |  | REG. NO.<br>8 2 0 4 2 2 5   |  |  |   |  |
|--|--|---|--|--|---|--|--|---|--|
| 1. FOR STATE REGISTRAR   |  |   |  |  | 2a. DATE OF DEATH MONTH DAY YEAR  |  |  |   | 2b. HOUR                                     |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br>Roy A. Steimer   |  |   |  |  | 2. 24 82  |  |  |   | 4:55 PM                                      |
| 3 SEX<br>Male  |  | 4 RACE<br>Caucasian   |  | 5 DATE OF BIRTH MONTH DAY YEAR<br>9 15 06  |   | 6 AGE (IN YEARS LAST BIRTHDAY)<br>75 YRS   |  | 7. IF UNDER 1 YEAR IF UNDER 24 HRS<br>MONTHS DAYS HOURS MIN |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Ill. USA  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |  | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9 BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.                        |  |   |  |
| 10 CITY OR TOWN OF DEATH<br>Baltimore  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Wyman Park Health System |  |  |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Ship captain |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Ship captain           |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE 13b. CITY 13c. CITY OR TOWN<br>MD Baltimore City   |  |   |  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br>2707 N. Calvert St.   |   |  |
| 14 FATHER'S NAME FIRST MIDDLE LAST<br>Alfred Steimer   |  |   |  |  | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Sen  |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>Yes  |  | 16b. SOCIAL SECURITY NO<br>(IF YES, GIVE WAR OR DATES)<br>071-12-4944   |  | 17 INFORMANT ADDRESS<br>medical record   |   |  |  |   |  |
| 11 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>cardiac failure</u><br>4241<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>severe cardiac disease</u> - <u>cardiac failure &amp; arrhythmias</u> 6 months<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |  |   |  |  |   |  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a: _____   |  |   |  |  |   |  |  |   |  |
| 19a. DATE OF OPERATION<br>NA   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br>NA  |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |   |  |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br>1702 N. Calvert Baltimore City MD   |   |  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from Feb 19 82, to Feb 24 19 82, that (I) (we) lost saw the deceased alive on Feb 24 19 82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                       |  |   |  |  |   |  |  |   |  |
| 22b. SIGNATURE<br>J. Zweier MD   |  |   |  |  | DEGREE<br>MD  |  |  | 22c. DATE SIGNED<br>2/25/82                                 |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Jay Zweier MD   |  |   |  |  | 22e. ADDRESS<br>Wyman Park Health System  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Cremation  |  | 23b. DATE<br>3/1/82   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Westview Crematory   |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Westview Baltimore City MD         |  |   |  |
| 24. FUNERAL DIRECTOR<br>Burgee Funeral Home 3631 Falls Road 21211  |  |   |  |  | 25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE<br>MAR 2 1982 James J. [Signature]     |  |  |   |  |





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral home, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  |   |  |   |  |  |  | 8 2 0 4 2 2 6                                |  |
|---|--|---|--|---|--|---|--|--|--|--|--|
| 1- FOR<br>STATE<br>REGISTRAR  |  | REG. NO.  |  |   |  |   |  |  |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Catherine Stevenson</b>   |  |   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>2 5 82</b> |   |  | 2b. HOUR<br><b>M</b>   |  |  |  |
| 3. SEX<br><b>Female</b>   |  | 4. RACE<br><b>black</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>3 14 19</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>62</b> YRS.   |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.   |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MD</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>       |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore city</b> MD.                               |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>1514 E. Oliver Street</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)                                |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |  |  |
| 13a. STATE<br><b>Md</b>   |  | 13b. COUNTY   |  | 13c. CITY OR TOWN<br><b>Baltimore</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>1514 E. Oliver Street</b>  |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Robert Jackson</b>   |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Carrie Gary</b>   |  |   |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>218-60-7982</b>  |  | 17. INFORMANT<br><b>Arthur Stevenson</b>  |  | ADDRESS<br><b>1514 E. Oliver St.</b>  |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>ACUTE MYO CARDIAL INFARCTION</b><br>4100<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>HYPERTENSION, DIABETIS MELLITUS</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. |  |   |  |   |  |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)<br><b>N/A</b>  |  |   |  |   |  |   |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART I OR PART 2)  |  |   |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET<br><b>3413 E. LOMBARD ST</b>  |  | CITY OR TOWN<br><b>BALTO.</b>   |  | COUNTY<br><b>MD</b>  |  | STATE  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____. that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |   |  |   |  |   |  |  |  |  |  |
| 22b. SIGNATURE<br><b>[Signature]</b>  |  |   |  | DEGREE<br><b>MD</b><br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  |   |  | 22c. DATE SIGNED<br><b>02/05/82</b>  |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>MADURA L PRABHAKAR M.D.</b>   |  |   |  | 22e. ADDRESS<br><b>3413 E. LOMBARD ST BAL 21224</b>   |  |   |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>2/10/82</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Mt. Auburn Cem.</b>  |  | 23d. LOCATION<br>CITY OR TOWN<br><b>Balto.</b>  |  | COUNTY<br><b>MD</b>  |  | STATE  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>William C. March F/H 1101 E. North Avenue</b>  |  |   |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>FEB 8 1982</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>   |  |  |  |

UNITED STATES DEPARTMENT OF AGRICULTURE  
WASHINGTON, D. C.



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Items 18b; 21a, b, c.; 21g; 25b5

STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 4 2 2 7

FOR 3/26/82 dad  
1. STATE REGISTRAR

REG. NO.

|  |  |   |   |  |  |   |  |
|--|--|---|---|--|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Michael Lonnie Stevenson</b>  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>2 18 82</b> |  |  | 2b. HOUR<br><b>12 25 PM</b>                   |  |
| 3. SEX<br><b>male</b>  | 4. RACE<br><b>caucasian</b>                | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>March 13 1953</b>  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>28 28</b> YRS.   |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.     |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>USA</b>  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b> | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.  |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Balt. City Hosp</b>                         |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Self-employed</b>                   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>-</b> |  |
| 13a. STATE<br><b>MD</b>  |  | 13b. COUNTY<br><b>--</b>  | 13c. CITY OR TOWN<br><b>Baltimore</b>                 | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>            |  |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Bob Stevenson</b>   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Margaret Fearl</b>  |   |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>-- --</b> |  | 16b. <b>219703292</b>   |   | 17. INFORMANT<br>ADDRESS<br><b>Baltimore, Md. 21224</b><br><b>Rose M. Stevenson, 3220 E. Fairmount Ave</b> |  |   |  |

|   |  |  |
|---|--|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>respiratory arrest</b><br>3040<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>aspiration</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>may have contributed but was unclear &amp; autopsy was refused</b> |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
|---|--|--|

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a:  
**pt. had pulled NG tube up into mouth**

|   |   |  |  |
|---|---|--|--|
| 19a. DATE OF OPERATION  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                          | 20a. AUTOPSY?<br>Refused<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)<br><b>Probably not</b><br><b>could be occurring</b> | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. <b>2/18/82 19</b> | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I, OR PART 2)<br><b>Anoxic brain damage 2° to heroin &amp; ETOR</b><br><b>C.D. pneumonia 2° aspiration 2° arrest</b> |  |
| 21d. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  | 21e. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                         |  |  |

22a. I certify that (I) (this hospital) attended the deceased from **Jan 16** 19 **82** to **Feb 18** 19 **82**, that (I) (we) lost saw the deceased alive on **Feb 18** 19 **82**, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.  
**Natural Respiratory arrest probably 2°**

|  |  |   |
|--|--|---|
| 22a. SIGNATURE<br><b>Valerie Brackett</b>                        | 22b. ADDRESS<br><b>Baltimore City Hosp</b> | 22c. DATE SIGNED<br><b>Feb 18, 1982</b> |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Valerie Brackett</b> |  |   |

|  |                                   |   |  |
|--|-----------------------------------|---|--|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>                                       | 23b. DATE<br><b>Feb. 20, 1982</b> | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Louden Park Cem. Baltimore, Md</b> | 23d. LOCATION<br>CITY OR TOWN COUNTY<br><b>Baltimore, Md</b> |
| 24. FUNERAL DIRECTOR<br><b>Schimunek Funeral Home, 3331 Brehms La, Baltimore, Maryland 21213</b> |                                   | 25a. DATE REC'D. BY REGISTRAR (SIGNATURE)<br><b>FEB 23 1982</b>             |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Handwritten text, mostly illegible due to fading and bleed-through. Some words like "B. H. H. H." and "B. H. H. H." are visible.

Handwritten text, mostly illegible due to fading and bleed-through. Some words like "B. H. H. H." and "B. H. H. H." are visible.



Items 13a-13e per phone 3/10/82 STATE OF MARYLAND  
 1 - dad  
 FOR dad  
 STATE REGISTRAR  
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
 CERTIFICATE OF DEATH  
 8 2 0 4 2 2 8  
 REG. NO.

|   |  |   |  |  |  |
|---|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>AMY LYNN Stewart   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>February 26 1982          |  | 2b. HOUR<br>3:17 AM  |
| 3. SEX<br>Female  | 4. RACE<br>Caucasian   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>2 26 82   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>0 YRS   | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN<br>2 40   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MD.  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.                           |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Univ. of Maryland |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE) |  | 12b. KIND OF BUSINESS OR INDUSTRY  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>Md.   |  |   | 13b. COUNTY<br>Dorchester  | 13c. CITY OR TOWN<br>Cambridge   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>N. DAVID Stewart  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>CAROLYN EASON   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)  |  | 16b. SOCIAL SECURITY NO.<br>—   |  | 17. INFORMANT<br>Horenstein MD. Univ of Md Hosp.                                     |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) 7708 Respiratory insufficiency<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) Severe prematurity<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>2 hrs 40 min |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a  |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART I OR PART 2)       |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 2/26/82 19 82 to 2/26 19 82, that (I) (we) lost saw the deceased alive on 2/26/82 19 82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                |  |   |  |  |  |
| 22b. SIGNATURE<br>Hadassah Orenstein MD   |  |   |  | 22c. DATE SIGNED<br>2/26/82  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Hadassah Orenstein MD  |  |   |  | 22e. ADDRESS<br>Univ of Md Hosp, 22 S. Greene St, Baltimore MD                       |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>BURIAL  |  | 23b. DATE<br>3/1/82   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>DORCHESTER MEM PK                              |  |
|   |  |   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>CAMBRIDGE DOR MD                       |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br>THOMAS FUNERAL HOME CAMBRIDGE MD  |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br>MAR 5 1982  |  |

MEDICAL CERTIFICATION

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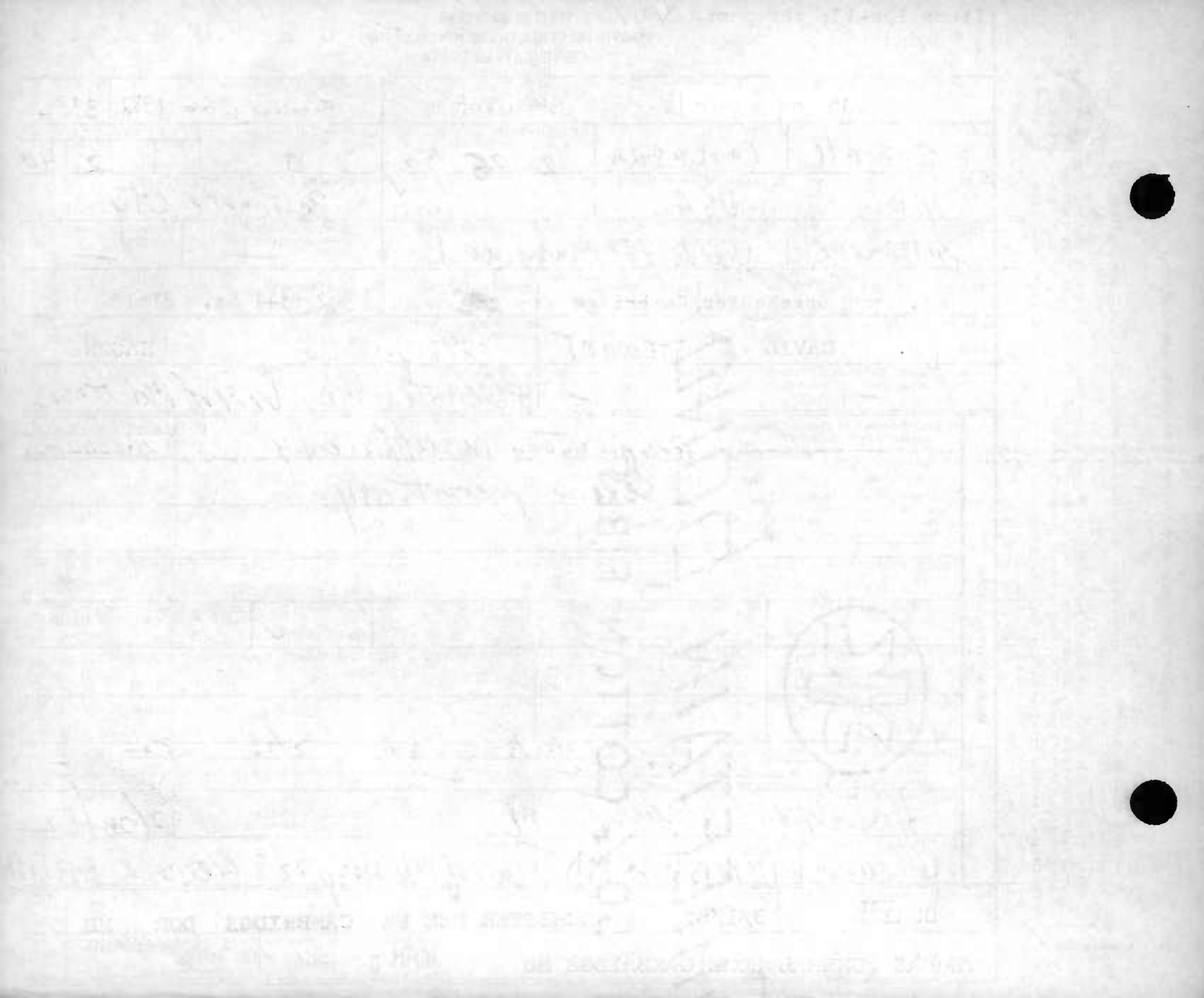
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers, Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
 IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified by the funeral director.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  |   |  |  |   |  |   |  |
|--|--|---|--|---|--|--|---|--|---|--|
| 1. FOR STATE REGISTRAR   |  |   |  |   | REG. NO.   |  |   |  |   |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>James Millard STIRLING</b>   |  |   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>February 19, 1982</b>  |  |   | 2b. HOUR<br><b>8:30P M</b>   |   |  |
| 3. SEX<br><b>Male</b>  |  | 4. RACE<br><b>White</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Aug 16, 1907</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>74</b> YRS.                                    |   | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.   |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City, MD.</b>                   |   |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Union Memorial Hospital</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Salesman</b>  |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Auto Parts.</b>  |   |  |
| 13a. STATE<br><b>Maryland</b>  |  |   |  |   | 13b. COUNTY<br><b>-----</b>  |  | 13c. CITY OR TOWN<br><b>Baltimore</b>                                       |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>William Millard Stirling</b>  |  |   |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Mary Eleanor Burke</b>   |  |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>No</b>  |  |   |  |   | 16b. SOCIAL SECURITY NO.<br><b>216-05-3596</b>   |  | 17. INFORMANT ADDRESS<br><b>Helen Ferol Stirling 3801 Yolando Rd. 21218</b> |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br><b>4100</b> IMMEDIATE CAUSE (a) <b>Cardiac Arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Myocardial infarction</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(c) <b>ASCD</b> |  |   |  |   |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>10 min</b>                                   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |   |  |   |  |  |   |  |   |  |
| 19a. DATE OF OPERATION   |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>      |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |   |  |   |  |
| 22a. I certify that (1) this hospital attended the deceased from <b>2/19, 1982</b> , to <b>2/19, 1982</b> , that (1) (we) lost saw the deceased alive on <b>2</b> 19 <b>1982</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) did (did not) view the body after death.                    |  |   |  |   |  |  |   |  |   |  |
| 22b. SIGNATURE<br><b>Warren M. Ross</b> M.D.   |  |   |  |   | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  |   | 22c. DATE SIGNED<br><b>2/19/82</b>   |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Warren M. Ross</b>   |  |   |  |   | 22e. ADDRESS<br><b>3900 N. Charles St. Apt 104 Balt 21208</b>  |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |  |   | 23b. DATE<br><b>Feb 22, 82</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Cathedral Cemetery</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore, Maryland</b>    |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Dippel Funeral Homes, Inc.</b>  |  |   |  |   | ADDRESS<br><b>7110 Belair Road<br/>Baltimore, Md.</b>  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>FEB 22 1982</b>                         |  | 25b. REGISTRAR'S SIGNATURE<br><b>Thomas J. [Signature]</b>                                      |  |



ALL INFORMATION CONTAINED  
HEREIN IS UNCLASSIFIED  
DATE 01-12-2010 BY 60322 JAW/STW

ORIGINAL MAINTAINED

FEB 23 1983

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 2 and 3 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be kept within 20 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |   |  |   |  |  |  | 8 2 0 4 2 3 0  |  |  |  |
|--|--|--|--|---|--|---|--|--|--|--|--|--|--|
| 1. FOR STATE REGISTRAR   |  |  |  |   |  |   |  |  |  | REG. NO.   |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>ADAM Lee STITELY</b>  |  |  |  |   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>FEBRUARY 15, 1982</b>                 |  |  |  | 2b. HOUR<br><b>10:00AM</b>   |  |  |  |
| 3. SEX<br><b>Male</b>  |  | 4. RACE<br><b>White</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Feb. 11 1982</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>YEARS MONTHS DAYS<br><b>4</b>                |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br><b>4</b>   |  | IF UNDER 24 HRS<br>HOURS MIN<br><b>4</b>   |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.               |  |  |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>THE JOHNS HOPKINS HOSPITAL</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>None</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>None</b>                                     |  |  |  |  |  |
| 13a. STATE<br><b>Maryland</b>  |  |  |  |   |  | 13b. COUNTY<br><b>Worcester</b>   |  | 13c. CITY OR TOWN<br><b>Berlin</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                            |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Wayne T. Stitely</b>  |  |  |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Kandis L. Hudson</b>        |  |  |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>No</b>  |  |  |  | 16b. SOCIAL SECURITY NO.<br><b>None</b>   |  | 17. INFORMANT ADDRESS<br><b>Wayne Stitely Berlin, Maryland</b>                  |  |  |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARDIO PULMONARY ARREST</b><br>7452<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>SEVERE ACIDOSIS + HYPOXIA</b><br>3 1/2 DAYS<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(c) <b>CONGENITAL TETRALOGY OF FALLOT</b><br>4 DAYS<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |  |  |   |  |   |  |  |  |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)   |  |  |  |   |  |   |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION<br><b>2/14/82</b>   |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>TETRALOGY OF FALLOT</b>  |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |  |  |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                               |  |  |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>2/14</b> , 19 <b>82</b> , to <b>2/15</b> , 19 <b>82</b> , that (I) (we) last saw the deceased alive on <b>2/15</b> , 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.   |  |  |  |   |  |   |  |  |  |  |  |  |  |
| 22b. SIGNATURE<br><b>Keith T. Silverman, MD</b>  |  |  |  |   |  | DEGREE<br><b>MD</b>   |  | 22c. DATE SIGNED<br><b>2/15/82</b>   |  |  |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>KEITH T. SILVERMAN, MD</b>   |  |  |  |   |  | 22e. ADDRESS<br><b>JOHN'S HOPKINS HOSP., BALTIMORE</b>                          |  |  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |  |  |  | 23b. DATE<br><b>2-17-1982</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Odd Fellows</b>                        |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Bishopville Worcester MD</b>        |  |  |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Charles W. Hastings, Selbyville, Del.</b>   |  |  |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>FEB 19 1982</b>                             |  | 25b. REGISTRAR'S SIGNATURE<br><b>Thomas J. [Signature]</b>                           |  |  |  |  |  |

MEDICAL CERTIFICATION

939

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH-16 50M 1/81  
(VRA 15, 4)

1- FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |   |   |  |  |
|--|--|---|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Rose Fowlkes Stith  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>February 1, 1982             |  | 2b. HOUR<br>12:40 <sup>AM</sup>                        |
| 3. SEX<br>Female   | 4. RACE<br>Black   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>9 28 09   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>72 YRS.                          | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.                      |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>VA  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.          |  |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Maryland General Hospital |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)    |  | 12b. KIND OF BUSINESS OR INDUSTRY                      |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>MD   |  |   | 13b. CITY OR TOWN<br>Columbia                                       |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>German H. Fowlkes  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Frances J. Jackson |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No   |  | 16b. SOCIAL SECURITY NO.<br>212-36-4957   |   | 17. INFORMANT<br>ADDRESS<br>May S. Ham 5644 High Tor Hill                            |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Respiratory Arrest<br>0389 } DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } Septicemia<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) |  |   |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>Sudden |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |   |   |  |  |
| 19a. DATE OF OPERATION<br>November 12, 1981  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br>Rectovaginal fistula  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)    |   |  |  |
| 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |   |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |
| 22a. I certify that (X) (this hospital) attended the deceased from October 29, 1981, to February 1, 1982, that (1) (we) lost saw the deceased alive on February 1, 1982, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) (did) (did not) view the body after death.                    |  |   |   |  |  |
| 22b. SIGNATURE<br>Georgina Groleau MD  |  | 22c. DATE SIGNED<br>2/1/82  |   | 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Georgina Groleau, M.D.                      |  |
| 22e. ADDRESS<br>C/O Maryland General Hospital  |  | 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial   |   |  |  |
| 23b. DATE<br>2/6/82  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Family Plot   |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Crewe VA                               |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Wm. C. March F/H   |  | 25a. DATE REC'D. BY REGISTRAR<br>FEB 3 1982   |   | 25b. REGISTRAR'S SIGNATURE<br>James J. Martin  |  |

MEDICAL CERTIFICATION

BP 4

12-50

February 1, 1943

John

Box

Baltimore City

Baltimore City Hospital

London

Administrative Record

Sanitation

x

Document 11, 1 (Governmental Affairs)

February 1, 1943

February

Georgia Institute of Technology

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |  |  |  |  |   |  | REG. NO. 82 04232                                |  |
|--|--|--|--|--|--|--|--|---|--|--|--|
| 1. FOR STATE REGISTRAR   |  | 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Franklin Paul Stone, SR.</b>  |  |  |  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>2/13/1982</b>   |  | 2b. HOUR<br><b>1 PM</b>                          |  |
| 3 SEX<br><b>male</b>   |  | 4 RACE<br><b>Caucasian</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>08-14-03</b>  |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>78</b>  |  | 7 UNDER 1 YEAR<br>MONTHS DAYS<br><b>08 14 03</b>  |  | 7 UNDER 24 HRS<br>HOURS MIN<br><b>1 PM</b>       |  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>  |  | 7b CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.                               |  |   |  |  |  |
| 10 CITY OR TOWN OF DEATH<br><b>Baltimore</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Baltimore City Hosp.</b> |  |  |  |  |  | 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>iron worker</b>                                     |  | 12b KIND OF BUSINESS OR INDUSTRY<br><b>Union</b> |  |
| 13a STATE<br><b>Maryland</b>   |  | 13b COUNTY<br><b>Balto.</b>  |  | 13c CITY OR TOWN<br><b>Baltimore</b>   |  | 13d INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e STREET ADDRESS<br><b>1000 Franklin Ave.</b>   |  | 13f ZIP CODE<br><b>21224</b>                     |  |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Charles Essex Stone</b>  |  | 15 MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Elsie Barnes</b>  |  | 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>Yes</b>  |  | 16b SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>218147832</b>                     |  | 17 INFORMANT<br>ADDRESS<br><b>Robert W. Stone, Sr. 3324 Foster Ave<br/>Baltimore, Md. 21224</b>                           |  |  |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Respiratory Arrest</b><br><b>1369</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost<br>(b) <b>Dehydration, infection</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) |  |  |  |  |  |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH     |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c)   |  |  |  |  |  |  |  |   |  |  |  |
| 19a DATE OF OPERATION  |  | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  |  | 20a AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>            |  | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |  |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c HOW INJURY OCCURRED<br>(ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |  |   |  |  |  |
| 21d INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |   |  |  |  |
| 22a I certify that (I) (this hospital) attended the deceased from <b>1/23</b> 19 <b>82</b> , to <b>2/13</b> 19 <b>82</b> , that (I) (we) lost<br>saw the deceased alive on <b>2/13</b> 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.                        |  |  |  |  |  |  |  |   |  |  |  |
| 22b SIGNATURE<br><b>Valerie Brackett</b>   |  | DEGREE<br><b>MD</b>  |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>                 |  |  |  | 22c DATE SIGNED<br><b>2/13/82</b>   |  |  |  |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Valerie Brackett</b>  |  | 22e ADDRESS<br><b>Baltimore City Hosp</b>  |  |  |  |  |  |   |  |  |  |
| 23a BURIAL, CREMATION, REMOVAL<br><b>Burial</b>  |  | 23b DATE<br><b>2/17/82</b>   |  | 23c NAME OF CEMETERY OR CREMATORY<br><b>St. Stanislaus Cem.</b>  |  |  |  | 23d LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Maryland</b>  |  |  |  |
| 24 FUNERAL DIRECTOR<br>NAME<br><b>Walter Brooks Bradley</b>  |  | ADDRESS<br><b>2135 Dundalk Ave</b>   |  | 25a DATE REC'D BY REGISTRAR<br><b>FEB 18 1982</b>  |  | 25b REGISTRAR'S SIGNATURE<br><b>Charles J. W. Wether</b>                                       |  |   |  |  |  |

*[Faint, illegible text, likely bleed-through from the reverse side of the page]*



DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 4 2 3 3

REG. NO.

FOR  
STATE  
REGISTRAR

|  |                         |  |        |   |                   |   |                    |   |                   |                                      |  |
|--|-------------------------|--|--------|---|-------------------|---|--------------------|---|-------------------|--------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |                         | FIRST<br><b>MARION</b>   | MIDDLE | LAST<br><b>STOWERS</b>  | 2a. DATE OF DEATH |   | MONTH<br><b>02</b> | DAY<br><b>14</b>                        | YEAR<br><b>82</b> | 2b. HOUR<br><b>3:07 PM</b>           |  |
| 3. SEX<br><b>MALE</b>  | 4. RACE<br><b>Negro</b> | 5. DATE OF BIRTH   |        | 6. AGE (IN YEARS LAST BIRTHDAY)   |                   | 7. UNDER 1 YEAR   |                    | 8. UNDER 24 HRS.                        |                   |                                      |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>USA GEORGIA</b>  |                         | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |        | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b>   |                    | MD.                                     |                   |                                      |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |                         | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br><b>South Baltimore General Hosp</b> |        | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>?</b>   |                   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>?</b>   |                    |   |                   |                                      |  |
| 13a. STATE<br><b>MD</b>  |                         | 13b. CITY OR TOWN<br><b>Baltimore</b>  |        | 13c. INSIDE CITY LIMITS?<br><b>YES</b> <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |                   | 13d. STREET ADDRESS<br><b>2723 Bookert Pk.</b>  |                    |   |                   |                                      |  |
| 14. FATHER'S NAME<br><b>JAMES</b>  |                         | 15. MOTHER'S MAIDEN NAME<br><b>LULA SIMPSON</b>  |        | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br><b>YES</b>   |                   | 16b. SOCIAL SECURITY NO.<br><b>257281669</b>  |                    | 17. INFORMANT<br><b>FRANCES STOWERS</b> |                   | ADDRESS<br><b>2723 BOOKERT DRIVE</b> |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I: DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a): <b>Acute massive encephalomalacia</b><br>4370<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:<br>(b) <b>Cerebral arteriosclerosis, severe</b><br>(c) <b>Generalized arteriosclerosis, severe</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (d):<br><b>Acute pulmonary edema bilateral, severe</b> |                         |  |        |   |                   |   |                    |   |                   | INTERVAL BETWEEN ONSET AND DEATH     |  |
| 19a. DATE OF OPERATION   |                         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |        | 20a. AUTOPSY?<br><b>YES</b> <input type="checkbox"/> NO <input type="checkbox"/>  |                   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br><b>YES</b> <input type="checkbox"/> NO <input type="checkbox"/> |                    |   |                   |                                      |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |                         | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>9 AM 19 82</b>                           |        | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 3 OR PART 2)  |                   |   |                    |   |                   |                                      |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |                         | 21e. PLACE OF INJURY<br>(1st HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                        |        | 21f. LOCATION<br>(STREET)   |                   | CITY OR TOWN  |                    | COUNTY                                  |                   | STATE                                |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>2/8</b> 19 <b>82</b> , to <b>2/11</b> 19 <b>82</b> that (I) (we) last saw the deceased alive on <b>2/11</b> 19 <b>82</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) (which) did not view the body after death.)   |                         |  |        |   |                   |   |                    |   |                   |                                      |  |
| 22b. SIGNATURE<br><b>STEVEN W. FEATON</b>  |                         | DEGREE<br><b>MD</b>  |        | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                  |                   | 22c. DATE SIGNED<br><b>2/11/82</b>  |                    |   |                   |                                      |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>STEVEN W. FEATON</b>   |                         | 22e. ADDRESS   |        |   |                   |   |                    |   |                   |                                      |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>BURIAL</b>   |                         | 23b. DATE<br><b>2/16/82</b>  |        | 23c. NAME OF CEMETERY OR CREMATORY<br><b>CEDAR HILL CEMETERY</b>  |                   | 23d. LOCATION<br>(CITY OR TOWN)   |                    | COUNTY                                  |                   | STATE                                |  |
| 24. FUNERAL DIRECTOR<br>(NAME)   |                         | ADDRESS  |        | 25a. DATE REC'D. BY REGISTRAR<br><b>FEB 16 1982</b>   |                   | 25b. REGISTRAR'S SIGNATURE<br><b>Thomas Jan North</b>   |                    |   |                   |                                      |  |
| <b>WM. C. MARCH F/H 1101 E. NORTH AVE.</b>   |                         |  |        |   |                   |   |                    |   |                   |                                      |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 2 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified at 1-800-368-5858.

903.2011

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the medical examiner, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in the office of the Registrar after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a report filed.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  | REG. NO. 8 2 0 4 2 3 4  |  |   |  |
|---|--|--|--|---|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) <b>Edna Mae Stromberg</b>  |  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR 2 14 82  |  |   |  |
| 3 SEX <b>Female</b>   |  |  |  | 7b. HOUR 12 AM  |  |   |  |
| 4 RACE <b>Caucasian</b>   |  | 5. DATE OF BIRTH MONTH DAY YEAR 5 14 09  |  | 6. AGE (IN YEARS LAST BIRTHDAY) 72 YRS  |  | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Baltimore, Md.</b>   |  | 7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>  |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>     |  | 9 BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.   |  |
| 10 CITY OR TOWN OF DEATH <b>Baltimore</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Mercy Hospital</b> |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Chief Operator</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY <b>Telephone Co.</b>  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE <b>Md.</b> 13b COUNTY <b>---</b> 13c CITY OR TOWN <b>Baltimore</b>   |  |  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |   |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST <b>Edward Swan</b>  |  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Mary Beatly</b>   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>   |  |  |  | 16b. SOCIAL SECURITY NO. <b>212-05-0158</b>   |  |   |  |
| 17. INFORMANT ADDRESS <b>Dolores Swan (sister) same address</b>   |  |  |  |   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY.<br>IMMEDIATE CAUSE (a) <b>Sepsis</b><br>3449<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Decubitus ulcers</b><br>? months<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Paraparesis</b><br>5 years    |  |  |  |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>Spinal cord tumor, diabetes</b>   |  |  |  |   |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2)  |  |   |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 1/4 19 82 to 2/14 19 82, that (I) (we) last saw the deceased alive on 2/13 19 82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |   |  |   |  |
| 22b. SIGNATURE <b>F. Wiegmann MD</b>  |  |  |  | DEGREE <b>MD</b> ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED <b>2/14/82</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>F. WIEGMANN</b>  |  |  |  | 22e. ADDRESS <b>Mercy Hospital</b>  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>   |  | 23b. DATE <b>2/17/82</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY <b>Moreland Mem. Park</b>  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE <b>Balto. Md.</b>   |  |
| 24. FUNERAL HOME <b>Schmunk Funeral Home, Inc.</b>  |  |  |  | 25a. DATE REC'D. BY REGISTRAR <b>FEB 16 1982</b>  |  |   |  |
| 24b. ADDRESS <b>3331 Brehms Lane, Balto. Md. 21213</b>  |  |  |  | 25b. REGISTRAR'S SIGNATURE <b>James Jan Thullen</b>   |  |   |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |   |   |   | 8-2 0 4 2 3 5   |  |
|---|---|---|---|---|--|
| 1. FOR<br>STATE<br>REGISTRAR  |   |   |   | REG. NO.  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>FREDERICK R. STROW</b>  |   |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>2-11-82</b>                                     |   | 2b. HOUR<br>MIN.<br><b>4:45</b> M                        |
| 3. SEX<br><b>Male</b>   | 4. RACE<br><b>White</b>   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Sept. 10, 1902</b>   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>79</b> YRS.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.                               |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>UNION MEMORIAL HOSPITAL</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Data Processor</b> |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>State of Md.</b> |
| 13a. STATE<br><b>Maryland</b>   |   | 13b. COUNTY<br><b>Baltimore</b>   | 13c. CITY OR TOWN<br><b>Towson</b>  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Frederick W. Strow</b>   |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Mary Read</b>                         |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>   |   | 16b. SOCIAL SECURITY NO.<br><b>215 09 8776</b>  |   | 17. INFORMANT<br>ADDRESS<br><b>Thomas E. Mace, Balto., Md.</b>                                  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARDIO RESPIRATORY ARREST</b><br><b>4100</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>ACUTE MYOCARDIAL INFARCTION</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |   |   |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH             |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)   |   |   |   |   |  |
| 19a. DATE OF OPERATION  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |   |   |   |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)                  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>1970</b> to <b>2/11</b> 19 <b>82</b> , that (I) (we) last saw the deceased alive on <b>1/11</b> 19 <b>82</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.   |   |   |   |   |  |
| 22b. SIGNATURE<br><b>Marcio M. Menendez MD</b>  |   | DEGREE<br><b>MD</b>   |   | 22c. DATE SIGNED<br><b>2/11/82</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>MARCIO M. MENENDEZ</b>  |   | 22e. ADDRESS<br><b>UNION MEMORIAL HOSPITAL</b>  |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Cremation</b>  |   | 23b. DATE<br><b>2/12/82</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Green Mount</b>  |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Balto., Md.</b>  |   |   |   |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Henry W. Jenkins &amp; Sons Co.</b><br><b>4905 York Road Balto., Md. 21212</b>   |   |   |   | 25a. DATE REC'D. BY REGISTRAR<br><b>FEB 16 1982</b>   |  |
|   |   |   |   | 25b. REGISTRAR'S SIGNATURE<br><i>Thomas E. Mace</i>   |  |

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For W. J. ...

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |   | REG. NO. 8 2 0 4 2 3 6   |  |  |  |   |
|--|--|--|---|--|--|--|--|---|
| 1. FOR STATE REGISTRAR   |  |  |   | 2a. DATE OF DEATH MONTH DAY YEAR 02-22-82  |  |  |  | 2b. HOUR 7:45 PM  |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Marion Stokes   |  |  |   |  |  |  |  |   |
| 3. SEX MALE  |  | 4. RACE BLACK  |   | 5. DATE OF BIRTH MONTH DAY YEAR 04-25-21   |  | 6. AGE (IN YEARS LAST BIRTHDAY) 60 YRS.  |  | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) South Carolina   |  | 7b. CITIZEN OF WHAT COUNTRY? USA   |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD                                       |  |   |
| 10. CITY OR TOWN OF DEATH Baltimore  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Lutheran Hospital |   |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                                |  | 12b. KIND OF BUSINESS OR INDUSTRY   |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |  |   |  |  |  |  |   |
| 13a. STATE Md.   |  | 13b. COUNTY  |   | 13c. CITY OR TOWN Baltimore  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS 29 S. Calverton Rd  |
| 14. FATHER'S NAME FIRST MIDDLE LAST Willie Stokes  |  |  |   | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Rosenna Caldwell  |  |  |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES NO OR UNKNOWN) NO  |  |  |   | 16b. SOCIAL SECURITY NO. 051263101   |  | 17. INFORMANT ADDRESS Mattie M. Stokes 29 S. Calverton                                       |  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) 4275 CARDIORESPIRATORY ARREST<br>DUE TO, OR AS A CONSEQUENCE OF (b) _____<br>DUE TO, OR AS A CONSEQUENCE OF (c) _____   |  |  |   |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) _____  |  |  |   |  |  |  |  |   |
| 19a. DATE OF OPERATION   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                    |  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19                |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART I OR PART 2)               |  |   |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  |  | 21f. LOCATION CITY OR TOWN COUNTY STATE  |  |   |
| 22a. I certify that (I) (this hospital) attended the deceased from Feb 11, 19 82, to Feb 22, 19 82, that (I) (we) last saw the deceased alive on Feb 22, 19 82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |  |  |   |  |  |  |  |   |
| 22b. SIGNATURE Eric Steckler MD DEGREE   |  |  |   |  |  | 22c. DATE SIGNED 2/22/82   |  |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Eric Steckler MD   |  |  |   |  |  | 22e. ADDRESS Lutheran Hosp. Balt MD  |  |   |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial   |  |  | 23b. DATE 2/27/82   |  | 23c. NAME OF CEMETERY OR CREMATORY Eastview Mem. Pk. |  | 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore MD |   |
| 24. FUNERAL DIRECTOR NAME C. March F/H 1101 E. North Ave.  |  |  |   |  |  | 25a. DATE REC'D. BY REGISTRAR FEB 25 1982  |  | 25b. REGISTRAR'S SIGNATURE  |





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a necropsy performed.

DHMH - 16 50M 1/81  
(VRA 15, 4)1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 4 2 3 1

REG. NO.

|   |  |   |   |  |  |   |  |   |  |
|---|--|---|---|--|--|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Charles F. Sulser</b>  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>2/11/82</b> |  |  | 2b. HOUR<br><b>11:30 P.M.</b>   |  |   |  |
| 3. SEX<br><b>male</b>   |  | 4. RACE<br><b>white</b>   |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>06 10 18</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>63</b>  |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.<br><b>YRS.</b>   |  |
| 8. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>West Virginia</b>  |  | 9b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD                                |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>South Baltimore General</b> |   |  |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Mechanic</b>             |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Chemical Ind.</b>   |  |
| 13a. STATE<br><b>md</b>   |  | 13b. COUNTY<br><b>Baltimore</b>   |   | 13c. CITY OR TOWN<br><b>Baltimore</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>John</b>   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Mary Unknown</b>  |   | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>Yes</b>  |  |   |  |   |  |
| 16b. SOCIAL SECURITY NO.<br><b>234-12-8697</b>  |  | 17. INFORMANT<br>NAME ADDRESS<br><b>Grace Youngbar Same as 13e</b>  |   | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Brain damage</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>cerebral vascular accident</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>4360</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |   |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>2 mos.</b>  |  |   |   |  |  |   |  |   |  |
| 19a. DATE OF OPERATION<br><b>N/A</b>  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   |  |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART I OR PART 2)   |  |   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>10/13</b> , 19 <b>81</b> , to <b>2/11</b> , 19 <b>82</b> , that (I) (we) lost<br>saw the deceased alive on <b>2/11</b> , 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above; (I) (we) (did) (did not) view the body after death. |  |   |   |  |  |   |  |   |  |
| 22b. SIGNATURE<br><b>Bob Winston</b>  |  | DEGREE  |   | 22c. DATE SIGNED<br><b>2/12/82</b>   |  |   |  | 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Bob Winston</b>   |  |
| 22e. ADDRESS<br><b>South Baltimore General Hospital</b>   |  | 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY) <b>Burial</b>  |   |  |  |   |  |   |  |
| 23b. DATE<br><b>2/15/82</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Glen Haven Mem Pk</b>  |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Glen Burnie A.A. Md</b>   |  | 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>George J. Gonce 4001 Ritchie Hgwy, Balto, Md</b>     |  |   |  |
| 25a. DATE REC'D. BY REGISTRAR<br><b>FEB 16 1982</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Thomas J. [Signature]</b>  |   |  |  |   |  |   |  |

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  |  |   |  |  |  |  |
|---|--|---|--|--|---|--|--|--|--|
| 1. FOR STATE REGISTRAR  |  |   |  |  | REG. NO. 8 2 0 4 2 3 8  |  |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>ALBERT DUTTON</b>   |  |   |  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>2 25 82</b>                            |  |  |  |  |
| 3 SEX<br><b>MALE</b>  |  | 4 RACE<br><b>BLACK</b>  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>12 1 15</b>  |   | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>66</b>  |  | 7b. HOUR<br><b>7:24 PM</b>   |  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>USA</b>  |  | 7b CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b>                                   |  | MD.  |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Univ. of Md. Hosp. &amp; I</b> |  |  |   | 12a USUAL OCCUPATION (TYPE OF WORK OR MOST OF WORKING LIFE)<br><b>8607 retired (UK occ.)</b>   |  | 12b KIND OF BUSINESS OR INDUSTRY   |  |
| 13a STATE<br><b>MD.</b>   |  | 13b COUNTY<br><b>BALT. CITY</b>   |  | 13c CITY OR TOWN<br><b>Baltimore</b>   |   | 13d INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e STREET ADDRESS<br><b>611 S. CHARLES ST.</b>  |  |
| 14 FATHER'S NAME FIRST MIDDLE LAST<br><b>WEST BROWN</b>   |  |   |  |  | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>HATTIE KENT</b>               |  |  |  |  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><b>no UK</b>  |  | 16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)<br><b>216-16-4933</b>   |  | 17 INFORMANT<br><b>William Kent</b>  |   | ADDRESS<br><b>Box 421 Lusby, Md.</b>   |  |  |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>cardiorespiratory arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>end stage renal failure, on hemodialysis.</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>years.</b>  |  |   |  |  |   |  |  |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>Pl on hemodialysis at time of arrest.</b>  |  |   |  |  |   |  |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                      |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)   |   |  |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |   |  |  |  |  |
| 22a. I certify that (1) this hospital attended the deceased from <b>2/25</b> , 19 <b>82</b> , to <b>2/25/82</b> , 19 <b>82</b> , that (2) (we) last saw the deceased alive on <b>same</b> , 19 <b>82</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) did (did not) view the body after death. |  |   |  |  |   |  |  |  |  |
| 22b. SIGNATURE<br><b>C.B. Howard MD</b>   |  |   |  |  | DEGREE<br><b>MD</b>   |  |  | 22c. DATE SIGNED<br><b>2/25/82</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>T.B. HAYWOOD MD</b>   |  |   |  |  | 22e. ADDRESS<br><b>Dept. of Med., Univ. of Md. Hospital</b>                   |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>Mar. 3-82</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Eastern Chapel Chr. Cem</b>   |   | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>Lusby Calvert Md.</b>                            |  |  |  |
| 24. FUNERAL DIRECTOR NAME<br><b>Spencer E. Sewell</b>   |  |   |  |  | 25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE<br><b>MAR 2 1982</b> |  |  |  |  |
| ADDRESS<br><b>Box 31, Prince Frederick, Md</b>  |  |   |  |  |   |  |  |  |  |



Special Agent in Charge, New York

Re: [illegible] [illegible] [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

1- FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 4 2 3 9

REG. NO.

|   |  |   |   |   |   |   |  |  |
|---|--|---|---|---|---|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>Arthur B. Swisher</b>  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>2 16 82</b> |   |   | 2b. HOUR<br><b>2:32 PM</b>  |  |  |
| 3. SEX<br><b>Male</b>   |  | 4. RACE<br><b>White</b>   |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>6 3 1911</b>   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>70</b> YRS.   |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>West Virginia</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.                               |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Good Samaritan Hospital</b> |   |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Electrician</b>          |  |  |
| 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Beth. Steel</b>   |  |   |   |   |   |   |  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |   |   |   |   |   |  |  |
| 13a. STATE<br><b>Maryland</b>   |  | 13b. COUNTY<br><b>Baltimore</b>   |   | 13c. CITY OR TOWN<br><b>Dundalk</b>   |   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |
| 13e. STREET ADDRESS<br><b>2022 Wareham Road</b>   |  |   |   |   |   |   |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Wesley Forest Swisher</b>  |  |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Mary Louise Jamison</b>   |   |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>218-07-3016</b>  |   | 17. INFORMANT<br><b>Rose E. Swisher</b>   |   | ADDRESS <b>2022 Wareham Rd. Balto., MD. 21222</b>   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARDIAC ARREST</b><br><b>4100</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>MYO CARD. IN INFARCTION</b><br>(c) <b>Arterio-sclerotic cardio vascular disease</b><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>MIN.</b><br><b>MIN.</b><br><b>Years</b> |  |   |   |   |   |   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>a</b>   |  |   |   |   |   |   |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |   |   |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |   |  |  |
| 22a. I certify that (I) (the hospital) attended the deceased from <b>July</b> , 19 <b>25</b> , to <b>Aug 12</b> , 19 <b>82</b> , that (I) (we) last saw the deceased alive on <b>Aug 12</b> , 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.   |  |   |   |   |   |   |  |  |
| 22b. SIGNATURE<br><b>Dr. Louis O. Olson</b>   |  |   |   | DEGREE<br><b>MD</b>   |   | 22c. DATE SIGNED<br><b>7/16/82</b>  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Dr. Louis O. Olson</b>  |  |   |   | 22e. ADDRESS<br><b>1012 OLD N. POINT RD. BALTO, MD. 21224</b>   |   |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>2/19/1982</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Meadowridge</b>  |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Dorsey Howard Maryland</b>                     |  |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Duda-Ruck, Inc. 7922 Wise Avenue Dundalk, MD. 21222</b>  |  |   |   | 25a. DATE REC'D. BY REGISTRAR<br><b>FEB 18 1982</b>   |   | 25b. REGISTRAR'S SIGNATURE<br><b>Anna J. Math</b>   |  |  |

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| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 | 14 | 15 | 16 | 17 | 18 | 19 | 20 | 21 | 22 | 23 | 24 | 25 | 26 | 27 | 28 | 29 | 30 | 31 | 32 | 33 | 34 | 35 | 36 | 37 | 38 | 39 | 40 | 41 | 42 | 43 | 44 | 45 | 46 | 47 | 48 | 49 | 50 | 51 | 52 | 53 | 54 | 55 | 56 | 57 | 58 | 59 | 60 | 61 | 62 | 63 | 64 | 65 | 66 | 67 | 68 | 69 | 70 | 71 | 72 | 73 | 74 | 75 | 76 | 77 | 78 | 79 | 80 | 81 | 82 | 83 | 84 | 85 | 86 | 87 | 88 | 89 | 90 | 91 | 92 | 93 | 94 | 95 | 96 | 97 | 98 | 99 | 100 |
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be called and examined.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  |   |  |  |  |  |  | 8 2 0 4 2 4 0   |  |
|--|--|---|--|---|--|--|--|--|--|---|--|
| 1- FOR STATE REGISTRAR   |  | REG. NO.  |  |   |  |  |  |  |  |   |  |
| 1. DECEASED NAME (TYPE OR PRINT) <b>Betty Jean Swisher</b>   |  |   |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR <b>2-27-82</b>  |  | 2b. HOUR <b>4:30P</b>  |  |   |  |
| 3. SEX <b>Female</b>   |  | 4. RACE <b>White</b>  |  | 5. DATE OF BIRTH MONTH DAY YEAR <b>Aug. 25, 1931</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY) <b>50</b>  |  | 7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.                              |  |   |  |
| 8. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>   |  | 7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>    |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.                               |  |  |  |   |  |
| 10. CITY OR TOWN OF DEATH <b>Baltimore</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN RESIDENCE, GIVE STREET ADDRESS) <b>John Hopkins Hospital</b> |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housekeeper</b>             |  | 12b. KIND OF BUSINESS OR INDUSTRY <b>Rectory</b>                       |  |   |  |
| 13a. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Maryland</b> 13b. CITY OR TOWN <b>Harford</b> 13c. CITY OR TOWN <b>Edgewood</b>  |  |   |  |   |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS <b>2306 Hanson Road</b>                            |  |   |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST <b>William --- League</b>  |  |   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Ethel Gertrude Richardson</b>   |  |  |  |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b>  |  | 16b. SOCIAL SECURITY NO. <b>270-28-1347</b>   |  | 17. INFORMANT ADDRESS <b>Edgewood, Md. Mrs. Dorothy M. Eyet, 325 Flying Point Rd,</b>   |  |  |  |  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Dehydration</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>Recurrent Endometrial Carcinoma.</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>1820</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last |  |   |  |   |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>3 day</b>   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |   |  |   |  |  |  |  |  |   |  |
| 19a. DATE OF OPERATION   |  |   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)               |  |  |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  |   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>2/27</b> , 19 <b>82</b> , to <b>same</b> , 19 <b>82</b> , that (I) (we) last saw the deceased alive on <b>2/27</b> , 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                   |  |   |  |   |  |  |  |  |  |   |  |
| 22b. SIGNATURE <b>Nathan G. Berger</b>   |  |   |  | DEGREE <b>MD</b> ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  |  |  | 22c. DATE SIGNED <b>2/27/82</b>  |  |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>NATHAN G. BERGER</b>  |  |   |  | 22e. ADDRESS <b>Johns Hopkins Hospital</b>  |  |  |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>  |  |   |  | 23b. DATE <b>Mar. 3, 1982</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY <b>Ebenezer Method. Cemetery Chase</b>                    |  | 23d. LOCATION CITY OR TOWN COUNTY STATE <b>Balto. Md.</b>              |  |   |  |
| 24. FUNERAL DIRECTOR <b>Howard K. McComas III, Abingdon, Md.</b>   |  |   |  |   |  | 25a. DATE REC'D. BY REGISTRAR <b>MAR 2 1982</b>  |  | 25b. REGISTRAR'S SIGNATURE <b>Charles VanNathan</b>                    |  |   |  |

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DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

106A

## MEDICAL CERTIFICATION

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(VR A15 ME (5))  
15M 2/80

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the death certificate with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified within 24 hours after death.

MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  | REG. NO. 8 2 0 4 2 4 2   |  |   |  |
|---|--|---|--|--|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>KATHERINE L. TANSILL</b>   |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR <b>02-07-82</b>   |  |   |  |
| 3. SEX <b>Female</b>  |  |   |  | 2b. HOUR <b>5:02 A</b>   |  |   |  |
| 4. RACE <b>White</b>  |  | 5. DATE OF BIRTH MONTH DAY YEAR <b>10 21 97</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY) <b>84</b>  |  | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>BALTIMORE</b>  |  | 7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |   |  |
| 10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>SIBGH</b> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>CITY of Baltimore</b> MD.  |  |   |  |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>RETIRED</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |  |  |   |  |
| 13a. STATE <b>MD</b>  |  | 13b. COUNTY <b>Baltimore</b>  |  | 13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 13e. STREET ADDRESS <b>518 E. FORT AVE.</b>   |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST <b>Frank MITCHELL</b>   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>MARY CRAIG</b>  |  |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>   |  | 16b. SOCIAL SECURITY NO. <b>220-46-7016</b>   |  | 17. INFORMANT ADDRESS <b>Mr. Melvin E. Tansill, 125 W. Ostend St. Balto. Md.</b>   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c):<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>ARRHYTHMIA, S/P CPR</b><br><b>2501</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last }<br>(b) <b>DIABETIC KETOACIDOSIS</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>DUE TO, OR AS A CONSEQUENCE OF</b> |  |   |  |  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>CONTRIBUTING TO DEATH</b>   |  |   |  |  |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |   |  |  |  |   |  |
| 22b. SIGNATURE <b>Winston Hugh Williams MD</b>  |  |   |  | DEGREE <b>MD</b>   |  | 22c. DATE SIGNED <b>2/7/92</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Winston Hugh Williams MD</b>   |  |   |  | 22e. ADDRESS <b>C/O South Baltimore General Hospital</b>   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>   |  | 23b. DATE <b>Feb. 10, 1982</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cemetery</b>  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore, Maryland</b>  |  |
| 24. FUNERAL DIRECTOR NAME <b>McCully Funeral Home, 130 E. Fort Ave. Balto. Md.</b>  |  |   |  | 25a. FILE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE <b>Thane J. [Signature]</b>   |  |   |  |
| 25c. DATE <b>FEB 10 1982</b>  |  |   |  |  |  |   |  |

14

RECEIVED  
JAN 10 1964  
U.S. DEPARTMENT OF AGRICULTURE  
WASHINGTON, D.C.

TO: DIRECTOR, AGRICULTURAL RESEARCH SERVICE  
FROM: [illegible]  
SUBJECT: [illegible]

Enclosed for the Director are two copies of a report  
dated and captioned as above. One copy of the report  
is being furnished to the [illegible] for their information.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

# STATE OF MARYLAND

## DEPARTMENT OF HEALTH AND MENTAL HYGIENE

### CERTIFICATE OF DEATH

8 2 0 4 2 4 3

1- FOR  
STATE  
REGISTRAR

REG. NO.

|  |   |   |  |   |  |
|--|---|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <i>Etha R. Tarkenton</i>   |   |   | 2a. DATE OF DEATH MONTH DAY YEAR <i>2/12/82</i>                                    |   | 2b. HOUR <i>2:04P</i>  |
| 3. SEX<br><i>FEMALE</i>  | 4. RACE<br><i>WHITE</i>   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><i>MARCH 27, 1905</i>   | 6. AGE (IN YEARS LAST BIRTHDAY) <i>76</i> YRS.                                     |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><i>MARYLAND</i>   | 7b. CITIZEN OF WHAT COUNTRY?<br><i>U.S.A.</i>   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><i>BALTIMORE CITY</i> MD.                  |   |  |
| 10. CITY OR TOWN OF DEATH<br><i>BALTIMORE</i>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br><i>UNION MEMORIAL HOSPITAL</i> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><i>AT Home</i> | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE <i>MD.</i>  |   |   | 13b. COUNTY <i>BALTIMORE</i>   | 13c. CITY OR TOWN <i>BALTIMORE</i>  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 13e. STREET ADDRESS<br><i>2817 Edison Highway</i>  |   |   | 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><i>EDWARD MATHIAS</i>                    |   |  |
| 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><i>CARRIE EASLEY</i>  |   |   | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <i>NO</i>     |   |  |
| 16b. SOCIAL SECURITY NO.<br><i>212-093524</i>  |   |   | 17. INFORMANT<br>ADDRESS<br><i>FAMILY RECORDS</i>                                  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>4310 Intra cerebral hematoma</i><br>DUE TO, OR AS A CONSEQUENCE OF (b) _____<br>DUE TO, OR AS A CONSEQUENCE OF (c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |   |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><i>3 weeks</i>                               |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><i>Staphylococcal Sepsis</i>   |   |   |  |   |  |
| 19a. DATE OF OPERATION<br><i>1/10/82</i>   |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><i>intra cerebral hematoma</i>  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>  |   | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)       |  |   |  |
| 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. <i>19</i>  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                 |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                |   |   |  |   |  |
| 22b. SIGNATURE<br><i>John B. Posey MD</i>  |   | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>        |  | 22c. DATE SIGNED<br><i>2/12/82</i>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><i>JOHN B. POSEY</i>  |   | 22e. ADDRESS<br><i>201 E. Univ. Pkwy</i>  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><i>BURIAL</i>  |   | 23b. DATE<br><i>2-16-1982</i>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><i>Dulaney Valley Timonium</i>              |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><i>BALTIMORE BALTIMORE MD.</i>   |   | 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><i>Erans Funeral Chapel 8800 HARFORD RD.</i>  |  |   |  |
| 25a. DATE REC'D. BY REGISTRAR (TYPE OR PRINT)<br><i>FEB 16 1982</i>  |   | 25b. REGISTRAR'S SIGNATURE<br><i>James J. [Signature]</i>   |  |   |  |

MEDICAL CERTIFICATION

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2643 BP



UNITED STATES

DEPARTMENT OF JUSTICE

WASHINGTON

February 10, 1965

Mr. J. Edgar Hoover

Sir:

~~Enclosed for you are~~

three copies of a letterhead memorandum

dated and captioned as above.

The letterhead memorandum is being

forwarded to you for your information.

Very truly yours,

John Edgar Hoover  
Director

FEB 16 1965

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 4 2 4 4

REG. NO.

|   |  |  |   |  |  |  |
|---|--|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>ROBERT Lee TAWES, SR.</b>   |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>FEBRUARY 28, 1982</b> |  | 2b. HOUR<br><b>20:40 PM</b>                  |  |
| 3. SEX<br><b>Male</b>   |  | 4. RACE<br><b>White</b>  |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Nov. 1 1914</b>   |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Md.</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>67</b> YRS.<br>IF UNDER 1 YEAR: MONTHS DAYS<br>IF UNDER 24 HRS: HOURS MIN. |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>THE JOHNS HOPKINS HOSPITAL</b>   |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.  |  |  |
| 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Correctional Officer</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>City of Balto.</b>   |   |  |  |  |
| 13a. STATE<br><b>Md.</b>  |  | 13b. COUNTY<br><b>-</b>  |   | 13c. CITY OR TOWN<br><b>Baltimore</b>  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Robert Tawes</b>   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Dawsey -</b>   |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>no</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>216-10-0735</b>   |   | 17. INFORMANT<br>ADDRESS<br><b>Robt. Tawes Jr. (son) same address</b>  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardio/pulmonary arrest</b><br><b>4782</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>retropharyngeal mass path pending</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>a</b>   |  |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                             |  |  |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>10:00 AM 2/28/82</b>                                       |  |  |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  | 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  |  |
| 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  | 22a. I certify that (I) (this hospital) attended the deceased from <b>2/26</b> , 19 <b>82</b> , to <b>2/28</b> , 19 <b>82</b> , that (I) (we) last saw the deceased alive on <b>2/28</b> , 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |   |  |  |  |
| 22b. SIGNATURE<br><b>Phil Buecher</b>   |  | DEGREE<br><b>MD</b>  |   | 22c. DATE SIGNED<br><b>2/28</b>  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Phil Buecher</b>  |  | 22e. ADDRESS<br><b>OHHA</b>  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>3/5/82</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Moreland Mem. Park</b>  |  |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Balto. Md.</b>   |  | 24. FUNERAL HOME<br><b>Schumnek Funeral Home, Inc.</b><br><b>3331 Brehms Lane, Balto. Md. 21213</b>  |   |  |  |  |
| 25a. DATE REC'D. BY REGISTRAR<br><b>MAR 3 1982</b>  |  | REGISTRAR'S SIGNATURE<br><b>Frances Jan Martin</b>   |   |  |  |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH-16 30M 2/80  
(VRA 15, 4)

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  |   |   |   |  |                                   |  |   |  |
|---|--|--|--|---|---|---|--|-----------------------------------|--|---|--|
| 1- FOR STATE REGISTRAR  |  |  |  |   | REG. NO.  |   |  |                                   |  |   |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Irvin F. Tawney</b>  |  |  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR <b>02-24-82</b> |   |  |                                   |  | 2b. HOUR<br><b>8:10 P</b>                                   |  |
| 3. SEX<br><b>Male</b>   |  | 4. RACE<br><b>Cau</b>  |  | 5. DATE OF BIRTH<br><b>10<sup>th</sup> 19<sup>th</sup> 02</b>   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>79</b>  |  | IF UNDER 1 YEAR<br>MONTHS DAYS    |  | IF UNDER 24 HRS.<br>HOURS MIN.                              |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MD</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTO. CITY</b> MD.                                  |  |                                   |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Perring Parkway Nursing Home</b> |  |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>RETIRED</b>              |  | 12b. KIND OF BUSINESS OR INDUSTRY |  |   |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |  | 13a. STATE<br><b>MD</b>  |   |   | 13b. COUNTY<br><b>---</b>   |  |                                   | 13c. CITY OR TOWN<br><b>BALTO.</b>   |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>?</b>  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>?</b>                                |   |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |                                   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>   |  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>213-05-9206</b>            |   |   | 17. INFORMANT<br>ADDRESS<br><b>SON</b>  |  |                                   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cancer of The Lungs</b><br><b>1629</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Cancer</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Cancer</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |  |  |   |   |   |  |                                   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>6 mo</b> |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a):  |  |  |  |   |   |   |  |                                   |  |   |  |
| 19a. DATE OF OPERATION  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       |  |                                   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, HOW BY MEDICAL EXAMINER?)   |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>                        |   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                  |  |                                   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)<br><b>2/24/82</b> |   |   | 21f. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>2/24/82</b>                                    |  |                                   | 21g. DATE SIGNED<br><b>2/25/82</b>   |   |  |
| 22. I certify that (I) (this hospital) attended the deceased from <b>2/24/82</b> to <b>2/24/82</b> that (I) (we) last saw the deceased alive on <b>2/24/82</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.   |  |  |  |   |   |   |  |                                   |  |   |  |
| 22a. SIGNATURE<br><b>Anthony F. Caputo</b>  |  |  | 22b. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Anthony F. Caputo</b>                        |   |   | 22c. ADDRESS<br><b>1801 N. Kentwood Rd Baltimore 21234</b>                                      |  |                                   | 22d. DATE SIGNED<br><b>2/25/82</b>   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br><b>BURIAL</b>  |  |  | 23b. DATE<br><b>2/26/82</b>  |   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>LAKE VIEW</b>  |  |                                   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>CARROLL CO. MD</b>  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Paul E. Chomicki</b>   |  |  | 24b. ADDRESS<br><b>3617 Chestnut Ave</b>   |   |   | 25. DATE REC'D. BY REGISTRAR<br><b>MAR 1 1982</b>   |  |                                   |  |   |  |

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of one.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  | REG. NO. 8 2 0 4 2 4 6   |  |   |  |
|---|--|--|--|--|--|---|--|
| 1. FOR STATE REGISTRAR  |  |  |  |  |  |   |  |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br><b>John Henry Taylor</b>  |  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>February 2, 1982</b>  |  | 2b. HOUR<br><b>7:33 P.M.</b>  |  |
| 3. SEX<br><b>Male</b>   |  | 4. RACE<br><b>Black</b>  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>12 1 10</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS HOURS MIN.<br><b>72</b>   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>GA</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Maryland General Hospital</b> |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| 13a. STATE<br><b>MD</b>   |  | 13b. COUNTY<br><b>Baltimore</b>  |  | 13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 13d. STREET ADDRESS<br><b>2012 Madison Avenue</b>   |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>Cruff Taylor</b>  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Nettie William</b>  |  |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>No</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>254-09-3136</b>   |  | 17. INFORMANT ADDRESS<br><b>8588 West Consul</b><br><b>Chester Lee Taylor Detroit, Mich.</b>   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Myocardial Infarction</b><br><b>4100</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Atherosclerotic Heart Disease</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) _____ |  |  |  |  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |   |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |   |  |
| 22a. I certify that (x) (this hospital) attended the deceased from <b>February 2, 19 1982</b> , to <b>February 2, 19 1982</b> that (x) (we) lost above, (y) (we) (did) (not) view the body after death.   |  |  |  |  |  |   |  |
| 22b. SIGNATURE<br><b>Harry M. Harris, M.D.</b>  |  |  |  | DEGREE<br><b>M.D.</b>  |  | 22c. DATE SIGNED<br><b>2/3/82</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  |  |  | 22e. ADDRESS<br><b>c/o Maryland General Hospital</b>   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>2/6/82</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Cedar Hill Cem.</b>   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>Baltimore Co. MD</b>  |  |
| 24. FUNERAL DIRECTOR NAME<br><b>Wm. C. March F/H</b>  |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>FEB 5 1982</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>James J. North</b>   |  |





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner may be notified of this.

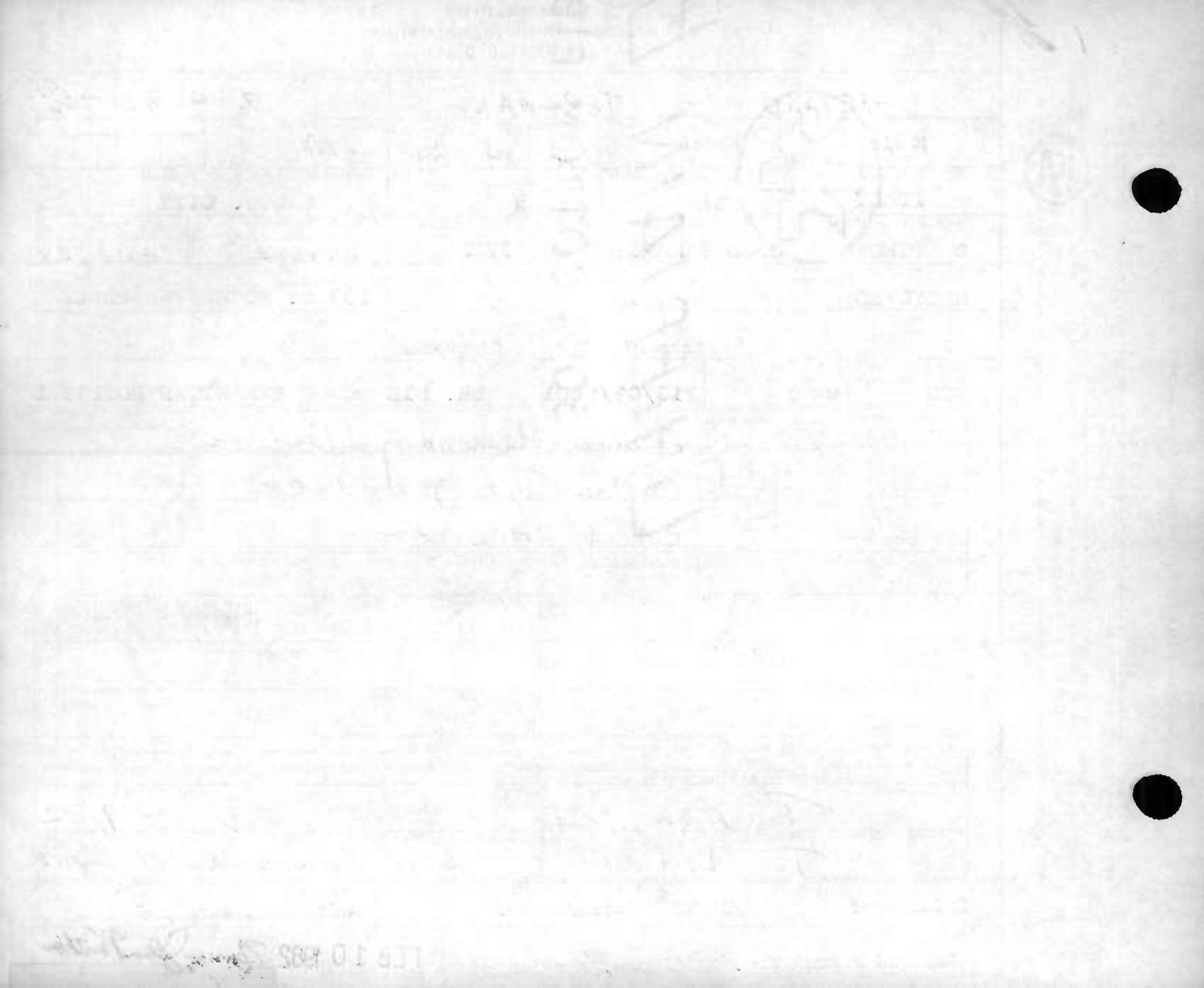
1. FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 4 2 4 7

REG. NO.

|  |  |  |  |   |  |  |
|--|--|--|--|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>GAETANO - TERAMANI</b>  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>2 9 82</b> |   | 2b. HOUR<br><b>7:25 A M</b>                  |  |
| 3. SEX<br><b>Male</b>  |  | 4. RACE<br><b>White</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>4 9 89</b>   |  |  |
| 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>92</b> YRS   |  | 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>ITALY</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  |  |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTO. CITY</b> MD  |  |   |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>GOOD SAMARITAN HOSPITAL</b>  |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>JEWELER</b>                                  |  |  |
| 12b. KIND OF BUSINESS OR INDUSTRY<br><b>JEWELRY</b>  |  | 13a. STREET ADDRESS<br><b>107 S. ROCHESTER PLACE</b>   |  | 13b. CITY OR TOWN<br><b>BALTO.</b>  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>? Teramani</b>  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Pasquarose ?</b>   |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>YES WW I</b> |  |  |
| 16b. SOCIAL SECURITY NO.<br><b>213/09/9601</b>   |  | 17. INFORMANT<br>ADDRESS<br><b>DR. LIN GOOD SAMARITAN HOSPITAL</b>   |  |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardio-Pulmonary Failure</b><br>1579<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(b) <b>Obstructive jaundice</b><br>(c) <b>CA of Pancreas</b> |  |  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c)  |  |  |  |   |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |  |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  |  |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)   |  | 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  |  |
| 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  | 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) lost<br>saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |  |   |  |  |
| 22b. SIGNATURE<br><b>T. Lin, MD</b>  |  | DEGREE<br><b>MD</b>  |  | 22c. DATE SIGNED<br><b>2/9/82</b>   |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>T. LIN, MD</b>   |  | 22e. ADDRESS<br><b>Good Samaritan Hospital</b>   |  | 23a. BURIAL, CREMATION, REMOVAL<br><b>Entombment</b>  |  |  |
| 23b. DATE<br><b>2/12/82</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Lorraine Park</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore, Maryland</b>  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Leonard J Ruck Inc. Baltimore, Maryland</b>   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>FEB 10 1982</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>James Santhorn</b>   |  |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 48 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 4 2 4 3

REG. NO.

|  |  |  |   |  |  |   |  |  |  |  |  |  |  |  |   |  |  |
|--|--|--|---|--|--|---|--|--|--|--|--|--|--|--|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Nathan  |  |  | 3. SEX<br>MALE  |  |  | 4. RACE<br>WHITE  |  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>05 01 04                                       |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>2 5 82  |  |  | 2b. HOUR<br>8 AM  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>NEW JERSEY  |  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>CITY   |  |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>DISPATCHER   |  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>TRUCKING   |  |  |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE   |  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>SINAI HOSPITAL |  |  | 12c. STREET ADDRESS<br>7000 FIELDCREST RD. 21215  |  |  | 13a. STATE<br>MARYLAND   |  |  | 13b. COUNTY<br>BALTIMORE   |  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>DAVID TEXER  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>SARAH UNKASMAN   |  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>NO  |  |  | 16b. SOCIAL SECURITY NO.<br>213-03-2845A   |  |  | 17. INFORMANT<br>MRS. ROSE TEXER   |  |  | 7000 FIELDCREST RD. BALTO., MD 21215  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION<br>4100<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) ASCVD<br>(c) DUE TO, OR AS A CONSEQUENCE OF |  |  |   |  |  |   |  |  |  |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)<br>FEO, ADDM   |  |  |   |  |  |   |  |  |  |  |  |  |  |  |   |  |  |
| 19a. DATE OF OPERATION<br>2/5/82   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  |   |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |   |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)   |  |  |  |  |  |  |  |  |   |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |  |  |  |  |  |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 2/5 19 82, to 2/5 19 82, that (I) (we) lost<br>saw the deceased alive on above, (I) (we) (did) (did not) view the body after death.   |  |  |   |  |  |   |  |  |  |  |  |  |  |  |   |  |  |
| 22b. SIGNATURE<br>Harvey Rosen MD  |  |  |   |  |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>        |  |  |  |  |  | 22c. DATE SIGNED<br>2/5/82   |  |  |   |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Harvey Rosen MD   |  |  |   |  |  | 22e. ADDRESS<br>BALTO., MD (SINAI HOSP.)  |  |  |  |  |  |  |  |  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>BURIAL   |  |  | 23b. DATE<br>FEB. 7, 1982   |  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>PROGRESSIVE BENEFIT & RELIEF ASSOC.   |  |  | 23d. LOCATION<br>RANDALLSTOWN BALTO. MD  |  |  |  |  |  |   |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>SOL LEVINSON & BROS., INC.<br>6010 REISTERSTOWN RD. BALTO., MD 21215   |  |  |   |  |  | 25a. DATE REC'D. BY REGISTRAR<br>FEB 11 1982  |  |  |  |  |  |  |  |  |   |  |  |

RECEIVED  
FEB 11 1965  
U.S. AIR FORCE  
HEADQUARTERS  
AIR FORCE  
WASHINGTON, D.C.



FEB 11 1965  
U.S. AIR FORCE  
HEADQUARTERS  
AIR FORCE  
WASHINGTON, D.C.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 4 2 4 9

1. FOR  
STATE  
REGISTRAR

REG. NO.

|   |  |   |   |  |  |
|---|--|---|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Ernest E. Thiemeyer  |  |   | 2a. DATE OF DEATH<br>February 17, 1982  |  | 2b. HOUR<br>8 <sup>20</sup> P. M.  |
| 3. SEX<br>Male  | 4. RACE<br>White   | 5. DATE OF BIRTH<br>March 30, 1900  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>81 YRS.  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.                                   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland   | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.                                      |  |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Long Green Nursing Home |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Retired - Manufacture Rep.  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |
| 13a. STATE<br>Maryland  | 13b. COUNTY  | 13c. CITY OR TOWN<br>Baltimore  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS<br>7 Middleton Court., 21212                               |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Edward H. Thiemeyer   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Sara J. McHarry  |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>No  |  | 16b. SOCIAL SECURITY NO.<br>350-10-2711   |   | 17. INFORMANT<br>ADDRESS<br>Mrs. Martha B. Thiemeyer, same as #13e             |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Pneumonia</u><br>1629 } DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Carcinoma of lung</u><br>DUE TO, OR AS A CONSEQUENCE OF (c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>3 mo.</u> |  |   |   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 11a.   |  |   |   |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>      | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Nov 28</u> , 19 <u>66</u> , to <u>Feb 15</u> , 19 <u>82</u> , that (I) (we) lost<br>saw the deceased alive on <u>Feb 9</u> , 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.   |  |   |   |  |  |
| 22b. SIGNATURE<br><u>William F. Fritz</u>   |  | DEGREE<br><u>MD</u>   |   | 22c. DATE SIGNED<br><u>2/18/82</u>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>William F. Fritz, M.D.   |  | 22e. ADDRESS<br>2 W. University Parkway   |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Cremation   |  | 23b. DATE<br>2-19-82  |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Loudon Park Crematory                    |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore, Maryland   |  | 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br>Ruck Towson Funeral Home, Inc., Towson, Md. 21204   |   |  |  |
| 25. DATE RECEIVED BY REGISTRAR<br>FEB 22 1982   |  | 26. REGISTRAR'S SIGNATURE<br><u>James J. Nathan</u>   |   |  |  |

MEDICAL CERTIFICATION

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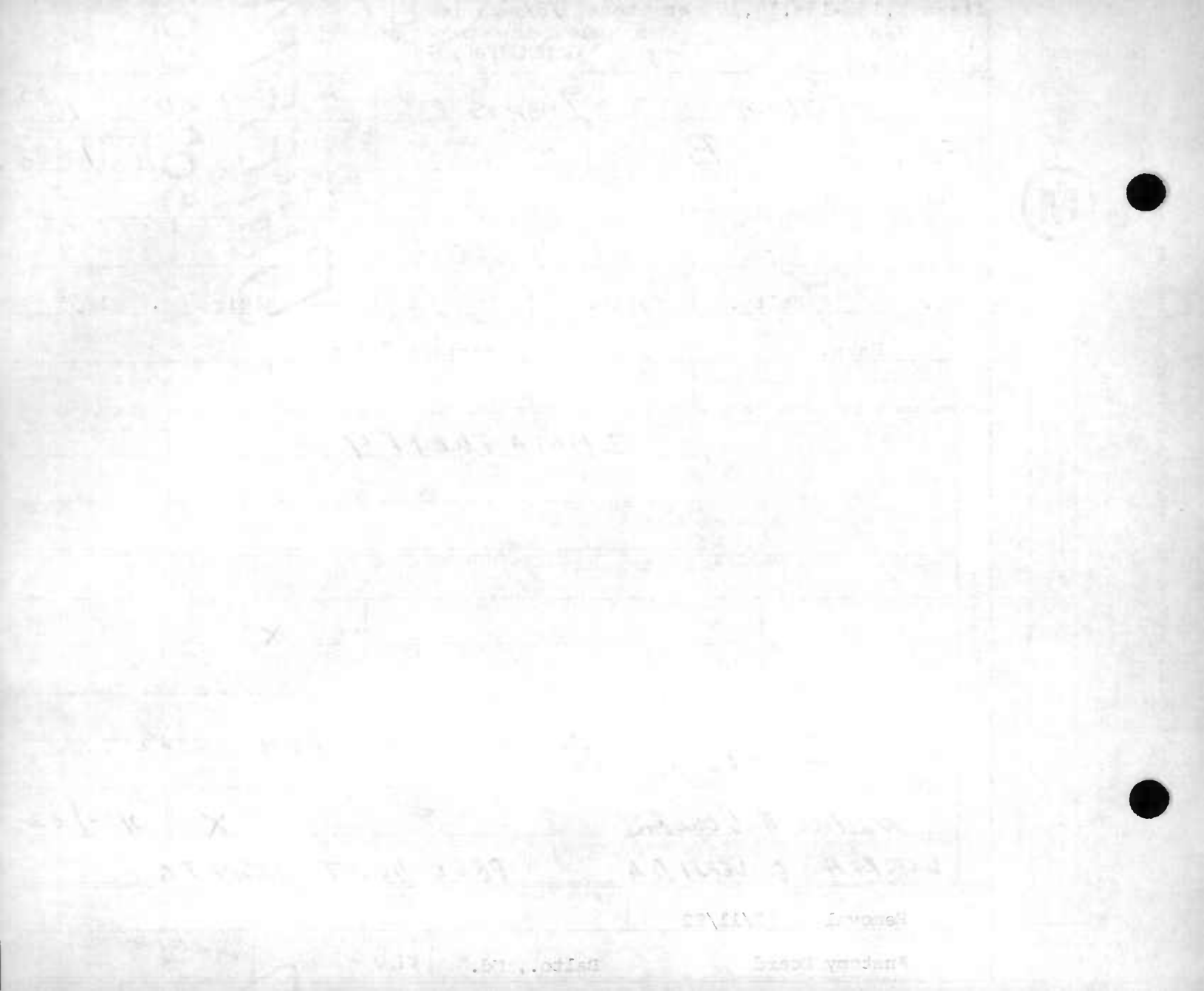
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in the office of the Registrar, Department of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |                              |  |  |  |  |  |   |  |  |  |  |  |
|--|--|------------------------------|--|--|--|--|--|---|--|--|--|--|--|
| 1. FOR<br>STATE<br>REGISTRAR   |  | dad                          |  | 8 2 0 4 2 5 0  |  | REG NO   |  |   |  |  |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  |                              |  | 2a. DATE OF DEATH  |  | MONTH  |  | DAY   |  | YEAR   |  | 2b. HOUR                                     |  |
| BETSYRA Thomas B.O.  |  |                              |  | 2  |  | 10   |  | 82  |  | 1005   |  | M  |  |
| 3 SEX  |  | 4. RACE                      |  | 5. DATE OF BIRTH   |  | 6. AGE (IN YEARS LAST BIRTHDAY)  |  | IF UNDER 1 YEAR   |  | IF UNDER 24 HRS  |  |  |  |
| Female   |  | B                            |  | 2 10 82  |  |  |  | MONTHS  |  | DAYS   |  | HOURS MIN                                    |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY? |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH   |  |   |  |  |  |  |  |
| Balt. Md   |  | USA                          |  |  |  | City   |  |   |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH  |  |                              |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)   |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)       |  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY            |  |
| Md.  |  |                              |  | PROVIDENT Hospital   |  |  |  |   |  |  |  |  |  |
| 13a. STATE   |  |                              |  | 13b. COUNTY  |  | 13c. CITY OR TOWN  |  | 13d. INSIDE CITY LIMITS?  |  | 13e. STREET ADDRESS  |  |  |  |
| Md.  |  |                              |  | Balto.   |  | Balto.   |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 6440 Falkirk Rd. 21239   |  |  |  |
| 14. FATHER'S NAME  |  |                              |  | 15. MOTHER'S MAIDEN NAME   |  |  |  |   |  |  |  |  |  |
| Unkn.  |  |                              |  | Barbara Thomas   |  |  |  |   |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)  |  |                              |  | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT ADDRESS  |  |   |  |  |  |  |  |
|  |  |                              |  |  |  |  |  |   |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>IMMATUREITY</u><br><u>7651</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____         |  |                              |  |  |  |  |  |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |                              |  |  |  |  |  |   |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  |                              |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  |  | 20a. AUTOPSY?   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |  |  |  |
|  |  |                              |  |  |  |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | YES <input type="checkbox"/> NO <input type="checkbox"/>       |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |                              |  | 21b. TIME OF INJURY  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |   |  |  |  |  |  |
|  |  |                              |  | HOUR A.M. MONTH DAY YEAR   |  |  |  |   |  |  |  |  |  |
|  |  |                              |  | P.M. 19  |  |  |  |   |  |  |  |  |  |
| 21d. INJURY OCCURRED   |  |                              |  | 21e. PLACE OF INJURY   |  | 21f. LOCATION  |  |   |  |  |  |  |  |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |                              |  | (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | STREET CITY OR TOWN COUNTY STATE   |  |   |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Feb 10</u> , 19 <u>82</u> , to <u>Feb 10</u> , 19 <u>82</u> , that (I) (we) last saw the deceased alive on <u>Feb 10</u> , 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |                              |  |  |  |  |  |   |  |  |  |  |  |
| 22b. SIGNATURE   |  |                              |  | DEGREE   |  |  |  | 22c. DATE SIGNED  |  |  |  |  |  |
| <u>Victoria G. Venida</u>  |  |                              |  |  |  |  |  | <u>2/10/82</u>  |  |  |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  |                              |  | 22e. ADDRESS   |  |  |  |   |  |  |  |  |  |
| <u>VICTORIA G. VENIDA</u>  |  |                              |  | <u>PROVIDENT HOSPITAL</u>  |  |  |  |   |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  |                              |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  |   |  | 23d. LOCATION  |  |  |  |
| Removal  |  |                              |  | 2/11/82  |  |  |  |   |  | CITY OR TOWN COUNTY STATE                                      |  |  |  |
| 24. FUNERAL DIRECTOR   |  |                              |  | 25a. DATE REC'D. BY REGISTRAR  |  |  |  | 25b. REGISTRAR'S SIGNATURE  |  |  |  |  |  |
| NAME   |  |                              |  | ADDRESS  |  |  |  |   |  |  |  |  |  |
| <u>Anatomy Board</u>   |  |                              |  | <u>Balto., Md.</u>   |  |  |  | <u>FEB 4 3 1982</u>   |  |  |  |  |  |





STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 4 2 5 1

REG. NO.

|  |  |   |   |  |                                    |  |   |  |  |
|--|--|---|---|--|------------------------------------|--|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>HAZEL F. THOMAS</b> |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>2-23-82</b>                 |  |                                    | 2b. HOUR<br><b>10<sup>PM</sup></b>   |   |  |  |
| 3. SEX<br><b>F</b>   |  | 4. RACE<br><b>Caucasian</b>   |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>1-14-31</b>   |                                    | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>51</b> YRS   |   | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.                |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>TENN</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                    | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City MD</b>   |   |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>              |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Home of Mrs. Hospital</b> |   |  |                                    | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Nurse's Aide</b>                      |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Nursing Home</b> |  |
| 13a. STATE<br><b>TENN</b>                                  |  |   | 13b. COUNTY<br><b>MSK</b>   |  | 13c. CITY OR TOWN<br><b>Britol</b> |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Jordan</b>    |  |   | 15. MOTHER'S NAME<br>FIRST MIDDLE LAST<br><b>Nellie Hazel Leonard</b> |  |                                    | 16. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>No</b> |   |  |  |
| 16b. SOCIAL SECURITY NO.                                   |  |   | 17. INFORMANT<br><b>Weaver Funeral Home, P.O. Box 324</b>             |  |                                    |  |   |  |  |

|   |  |  |  |
|---|--|--|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Acute Monocytic Leukemia</b><br>2060<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
|---|--|--|--|

|   |  |   |  |
|---|--|---|--|
| PART 2 - OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a<br><b>FULMINANT HEPATITIS - Adult Respiratory Distress syndrome</b> |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |
| 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  |
| 21f. LOCATION<br>STREET   |  | CITY OR TOWN COUNTY STATE   |  |

|   |  |   |  |
|---|--|---|--|
| 22a. I certify that (I) (this hospital) attended the deceased from <b>2-1-82</b> to <b>2-23-82</b> that (I) (we) last saw the deceased alive on <b>2-23-82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |  |   |  |
| 22b. SIGNATURE<br><b>Leonard F. Reedy</b>   |  | 22c. ADDRESS<br><b>Baltimore, MD, 21201</b> |  |
| 22d. PHYSICIAN'S NAME (Type or Print)<br><b>Leonard F. Reedy</b>  |  | 22e. ADDRESS<br><b>Baltimore, MD, 21201</b> |  |

|   |  |                                   |  |   |  |  |  |
|---|--|-----------------------------------|--|---|--|--|--|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>            |  | 23b. DATE<br><b>Feb. 26, 1982</b> |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Glenwood</b> |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Bristol Sullivan, Tenn.</b> |  |
| 24. FUNERAL DIRECTOR<br><b>ROBERT C. ALTENBURG FUNERAL HOME, INC.</b> |  |                                   |  | 25. DATE RECEIVED BY REGISTRAR<br><b>FEB 26 1982</b>  |  | 26. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>                              |  |
| 6009 Harford Rd., Balto., Md. 21214                                   |  |                                   |  |   |  |  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4, may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified.

MEDICAL CERTIFICATION

BP



1917  
No. 1  
The following is a list of the plants  
which have been introduced into the  
United States from foreign countries  
since the year 1900, and which are  
now being grown in the United States  
for commercial purposes.  
The list is arranged in alphabetical order  
of the names of the plants.  
The names of the plants are given in  
English, and the names of the countries  
from which they were introduced are  
given in parentheses.  
The list is divided into two parts,  
one for plants introduced from  
foreign countries, and the other for  
plants introduced from the United States.  
The first part of the list contains  
the names of the plants introduced  
from foreign countries, and the second  
part contains the names of the plants  
introduced from the United States.  
The list is arranged in alphabetical order  
of the names of the plants.  
The names of the plants are given in  
English, and the names of the countries  
from which they were introduced are  
given in parentheses.  
The list is divided into two parts,  
one for plants introduced from  
foreign countries, and the other for  
plants introduced from the United States.  
The first part of the list contains  
the names of the plants introduced  
from foreign countries, and the second  
part contains the names of the plants  
introduced from the United States.

From the Department of Agriculture

1917  
No. 1  
The following is a list of the plants  
which have been introduced into the  
United States from foreign countries  
since the year 1900, and which are  
now being grown in the United States  
for commercial purposes.  
The list is arranged in alphabetical order  
of the names of the plants.  
The names of the plants are given in  
English, and the names of the countries  
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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  | REG. NO. 8204252   |  |   |  |
|---|--|--|--|--|--|---|--|
| 1. FOR STATE REGISTRAR  |  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR 02-17-82  |  |   |  |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST GEORGIA E THOMAS   |  |  |  | 2b. HOUR 2:20pm  |  |   |  |
| 3. SEX Female   |  | 4. RACE White  |  | 5. DATE OF BIRTH Nov. 6, 1947  |  | 6. AGE (IN YEARS LAST BIRTHDAY) 34  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Wicomico Cty, Md.   |  | 7b. CITIZEN OF WHAT COUNTRY? U. S. A.                                      |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD  |  |
| 10. CITY OR TOWN OF DEATH BALTO., CITY  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION St. Agnes Hospital |  | 12a. USUAL OCCUPATION Registered Nurse   |  | 12b. KIND OF BUSINESS OR INDUSTRY Hosp.   |  |
| 13a. STATE Md.  |  |  |  | 13b. COUNTY Baltimore  |  | 13c. CITY OR TOWN Catonsville   |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST Harry B. Bell   |  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Elizabeth M. Adkins   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No  |  | 16b. SOCIAL SECURITY NO. 216-56-1851                                       |  | 17. INFORMANT Vincent P. Thomas-824 Braeside Rd.   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) 1. CARDIAC ARREST - EXTENSIVE<br>3418<br>DUE TO, OR AS A CONSEQUENCE OF (b) 1. INTERSEPTAL AND INFILTRATIVE PNEUMONIAL INFECTION<br>(c) 2. CHRONIC RENAL FAILURE.<br>3. HYPOKALAEMIC DYSTROPHY<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) DIABETES MELLITUS |  |  |  |  |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                           |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19                       |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |   |  |
| 21d. INJURY OCCURRED  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)        |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 2/13/1982 to 2/17/1982 that (I) (we) last saw the deceased alive on 2/17/1982 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |  |  |  |  |   |  |
| 22b. SIGNATURE (Type or Print) Anthony T. Fattopoulos   |  |  |  | 22c. DEGREE  |  | 22d. DATE SIGNED  |  |
| 22e. PHYSICIAN'S NAME (TYPE OR PRINT) ANTHONY T. FATTOPOLIS   |  |  |  | 22f. ADDRESS 9115 LEEDS AVE, SPRINGHILL  |  | 22g. CITY OR TOWN COUNTY STATE  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial  |  | 23b. DATE Feb. 20, 1982  |  | 23c. NAME OF CEMETERY OR CREMATORY Springhill Memory Gardens   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE Salisbury, Maryland   |  |
| 24. FUNERAL DIRECTOR Sterling Funeral Estate  |  | 24b. ADDRESS 736 Edmondson Ave. Catonsville, Md. 21225                     |  | 25a. DATE REC'D. BY REGISTRAR FEB 25 1982  |  | 25b. REGISTRAR'S SIGNATURE  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It is to be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use on the burial/transit permit. There please remove carbon papers. Pages 1 and 2 should be filed with the funeral home with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  |   |  |   |  |  |  | REG. NO.<br>8204253  |  |
|--|--|---|--|---|--|---|--|--|--|--|--|
| 1. FOR STATE REGISTRAR   |  |   |  |   |  | 2a. DATE OF DEATH   |  |  |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <i>Thomas Louis M</i>  |  |   |  |   |  | MONTH DAY YEAR<br><i>2-12-82</i>  |  |  |  | 2b. HOUR<br><i>11 AM</i>   |  |
| 3. SEX<br><i>M</i>   |  | 4. RACE<br><i>B</i>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><i>9 14 44</i>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><i>37</i> YRS.   |  | IF UNDER 1 YEAR<br>MONTHS DAYS   |  | IF UNDER 24 HRS.<br>HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><i>Md</i>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><i>U.S.A</i>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><i>City</i> MD.   |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><i>BALTO</i>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><i>University Hosp</i> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)                                |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |   |  |   |  | 13e. STREET ADDRESS   |  |  |  |  |  |
| 13a. STATE<br><i>Md</i>  |  | 13b. COUNTY   |  | 13c. CITY OR TOWN<br><i>BALTO</i>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><i>1539 Fulton Ave</i>  |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><i>Louis Thomas</i>  |  |   |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST   |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><i>Yes</i>   |  |   |  | 16b. SOCIAL SECURITY NO.<br><i>1961-1963</i>  |  | 17. INFORMANT ADDRESS<br><i>Milton Troye 2103 Ridgehill Ave</i>                                 |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Cardiopulmonary arrest</i><br>4275<br>DUE TO, OR AS A CONSEQUENCE OF (b) <i>Ⓢ</i><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost<br>DUE TO, OR AS A CONSEQUENCE OF (c) <i>status post CNS trauma (old)</i> |  |   |  |   |  |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a   |  |   |  |   |  |   |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  |   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><i>P.M. 19</i>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART I OR PART 2)                  |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  |   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____ above, (I) (we) (did) (did not) view the body after death.  |  |   |  |   |  |   |  |  |  |  |  |
| 22b. SIGNATURE<br><i>John C. [Signature]</i>   |  |   |  |   |  | DEGREE<br><i>MD</i>   |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br><i>2/12/82</i>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  |   |  |   |  | 22e. ADDRESS  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><i>Burial</i>   |  |   |  | 23b. DATE<br><i>2/16/82</i>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><i>Mt. Auburn</i>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><i>BALTO MD</i>  |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><i>Vernon B. Bailey</i>  |  |   |  |   |  | ADDRESS<br><i>1348 N. Calhoun St</i>  |  | 25a. DATE REC'D. BY REGISTRAR<br><i>FEB 16 1982</i>  |  | 25b. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>   |  |







TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  |   |  |   |  |  |  |
|---|--|---|--|---|--|---|--|--|--|
| 1. DECEASED NAME<br>(FARMER) ELMER John Thomas THOMPSON   |  |   |  |   |  |   |  |  |  |
| 3 SEX<br>MALE   |  | 4 RACE<br>BLACK   |  | 5. DATE OF BIRTH<br>MONTH 6 DAY 07 YEAR 09  |  | 2a. DATE OF DEATH<br>MONTH 2 DAY 22 YEAR 82   |  | 2b. HOUR<br>5:38 a.m.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MARYLAND   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>72 YRS.  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.   |  |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>VAMC BALTIMORE, MARYLAND 21218 |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)                                |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13a. STATE<br>MARYLAND  |  | 13b. COUNTY   |  | 13c. CITY OR TOWN<br>BALTIMORE  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br>732 N. Patterson Park Ave   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Jesse Thompson  |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE<br>Mabel Woolford  |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>YES WW1   |  |   |  | 16b. SOCIAL SECURITY NO.<br>218-01-9585   |  | 17. INFORMANT<br>ADDRESS<br>Mabel Thompson 827 N. Arlington Ave.                                |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY:<br>4275 IMMEDIATE CAUSE (a) <u>Cardiopulmonary Arrest</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.  |  |   |  |   |  |   |  |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a  |  |   |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |  |  |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>FEBRUARY 19, 1982</u> , to <u>FEBRUARY 22, 1982</u> , that <input checked="" type="checkbox"/> (we) lost<br>saw the deceased alive on <u>FEBRUARY 22, 1982</u> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated<br>above, <input checked="" type="checkbox"/> (we) (did) (not) view the body after death. |  |   |  |   |  |   |  |  |  |
| 22a. SIGNATURE<br>Anthony Foong MD  |  |   |  | DEGREE  |  |   |  | 22c. DATE SIGNED   |  |
| 22b. PHYSICIAN'S NAME (TYPE PRINT)<br>Anthony Foong MD  |  |   |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>                  |  |   |  | 22e. ADDRESS   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial  |  | 23b. DATE<br>2/26/82  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Md. Veteran Cem.  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Crownsville MD                                    |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Wm. C. March F/H 1101 E. North Ave.   |  |   |  | 25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE<br>FEB 23 1982 James J. Nathan   |  |   |  |  |  |



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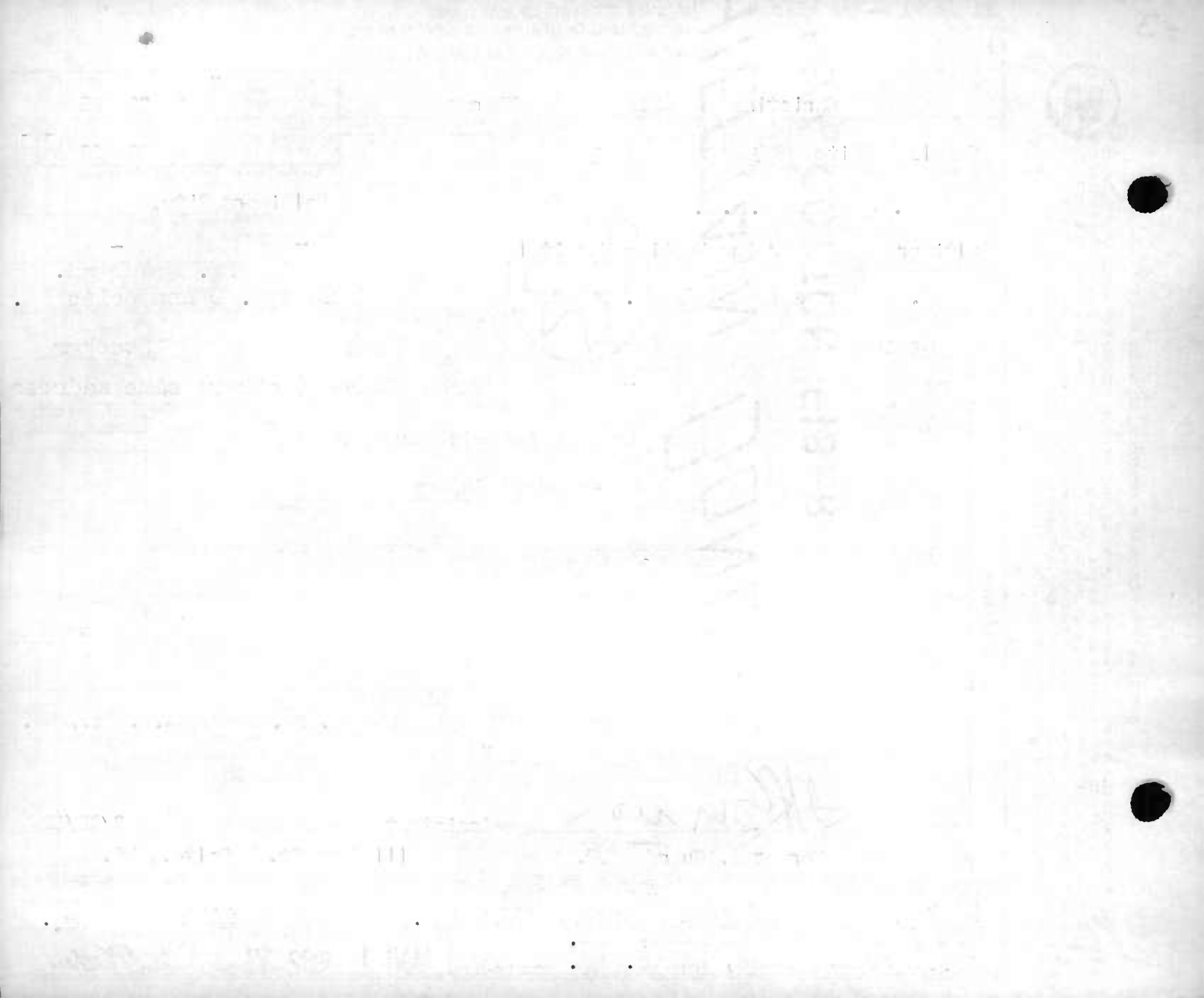
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DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

## MEDICAL CERTIFICATION

DHMH - 17  
(VR A15 ME (5))  
15M 2/80

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 4 2 5 6

1- FOR  
STATE  
REGISTRAR

REG. NO.

|   |   |   |  |  |  |
|---|---|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Thomas E Thrasher Sr</b>  |   |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>February 6, 1982</b>   |  | 2b. HOUR<br>M  |
| 3. SEX<br><b>Male</b>   | 4. RACE<br><b>White</b>   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Oct 28, 1935</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>46</b>   | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.                    |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>1510 Sheffield Rd</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Brick Mason</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY  |
| 13a. STATE<br><b>Maryland</b>   |   |   | 13b. COUNTY  | 13c. CITY OR TOWN<br><b>Baltimore</b>  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Richard B Thrasher</b>   |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Mattie E Howard</b>  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>   |   | 16b. SOCIAL SECURITY NO.<br><b>213-32-6212</b>  |  | 17. INFORMANT<br>ADDRESS<br><b>Mrs Peggy Thrasher Same</b>                           |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Myocardial Infarction</b><br><b>4100</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>ASCVD</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(c) <b>HBP</b> |   |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>Obesity</b>   |   |   |  |  |  |
| 19a. DATE OF OPERATION  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)   |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2)   |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>during Jan, 1982</b> 19 <b>82</b> the (I) (we) lost <b>above (I) (we) (did) (did not) see the body after death</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated  |   |   |  |  |  |
| 22b. SIGNATURE<br><b>Robert V. Varipapa</b>   |   |   | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br><b>2-7-82</b>  |
| 22e. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>ROBERT VARIPAPA</b>   |   |   | 22f. ADDRESS<br><b>Union Memorial Hosp. Baltimore, Maryland</b>  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   | 23b. DATE<br><b>2/6/82</b>  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Gardens Of Faith</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore, Maryland</b>             |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Leonard J Ruck Inc. Baltimore, Maryland</b>  |   |   | 25a. DATE REC'D. BY REGISTRAR<br><b>FEB 9 1982</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Thomas J. [Signature]</b>   |



RECEIVED  
FEB 11 1911

MAILED  
FEB 11 1911



Handwritten text, possibly a signature or address, at the bottom right.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of this.

FOR  
1. STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 4 2 5 7

REG. NO.

|   |  |   |  |   |  |
|---|--|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>WILLIAM A TICE   |  |   | 2a. DATE OF DEATH<br>MONTH 25 YEAR 82  |   | 2b. HOUR<br>12 M   |
| 3. SEX<br>MALE  | 4. RACE<br>CAUCASIAN   | 5. DATE OF BIRTH<br>MONTH 12 DAY 04 YEAR 12   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>69 YRS  | IF UNDER 1 YEAR<br>MONTHS DAYS  | IF UNDER 24 HRS<br>HOURS MIN.  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>USA Maryland   | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.                                 |   |  |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>UNIVERSITY OF MARYLAND HOSP |   | 12. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Master Mechanic RETIRED |   | 12b. KIND OF BUSINESS OR INDUSTRY<br>Revere Copper   |
| 13a. STATE<br>MD.   |  | 13b. COUNTY<br>—  | 13c. CITY OR TOWN<br>BALTIMORE   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS<br>1344 W. 41 <sup>ST</sup> STREET   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>EUGENE TICE   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>CLARA PEARCE   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>NO  |  | 16b. SOCIAL SECURITY NO.<br>213-03-4110   | 17. INFORMANT<br>ADDRESS<br>PATIENT CHART Lois M. Tice Same                                |   |  |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY.<br>IMMEDIATE CAUSE (a) 3940 CARDIO-PULMONARY ARREST<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) CONGESTIVE HEART FAILURE<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) RENAL FAILURE                                  |  |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>5 MINUTES<br>YEARS<br>3 WEEKS  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a<br>HEPATIC FAILURE  |  |   |  |   |  |
| 19a. DATE OF OPERATION<br>2-2-82  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br>MITRAL VALVE STENOSIS   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)                  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 1-31-82, 19 82, to 2-25, 19 82, that (I) (we) last saw the deceased alive on 2-25, 19 82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |  |   |  |
| 22b. SIGNATURE<br>Lauren A. Schnaper MD   |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>        |  | 22c. DATE SIGNED<br>2-26-82   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>LAUREN A. SCHNAPER   |  | 22e. ADDRESS<br>UNIV. OF MD. HOSPITAL BALTIMORE, MD. 21201  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial  |  | 23b. DATE<br>1 March 1982   | 23c. NAME OF CEMETERY OR CREMATORY<br>Druid Ridge Cemetery                                 |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Pikesville Balto. Co. Md   |
| 24. FUNERAL DIRECTOR<br>Burge Funeral Home 3631 Falls Rd. 21211   |  | 25a. DATE REC'D. BY REGISTRAR<br>MAR 2 1982   |  |   |  |
|   |  | 25b. REGISTRAR'S SIGNATURE<br>Francis J. Nathan   |  |   |  |



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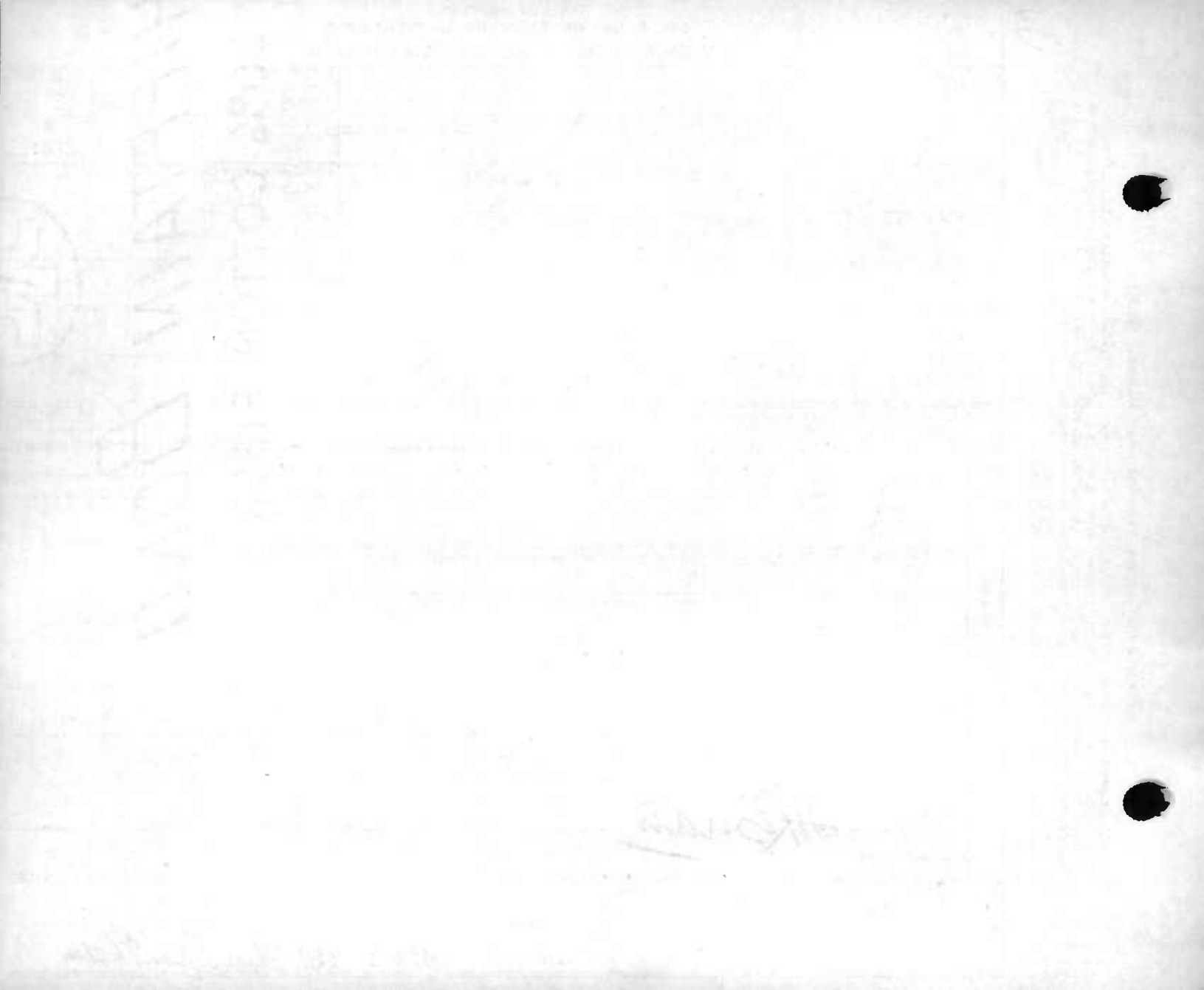
6000 1990-91

1010

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |  |                  |  |   |  |  |  |   |  | REG. NO. 2 0 4 2 5 8   |  |
|--|--|------------------|--|---|--|--|--|---|--|--|--|
| 1. FOR STATE REGISTRAR   |  |                  |  |   |  |  |  |   |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br>Andiya (Andoya) B. (Timmons) Timpson   |  |                  |  |   |  |  |  |   |  | 2a. DATE KNOWN OF DEATH ESTIMATED<br>MONTH DAY YEAR<br>2 27 82 |  |
| 3. SEX<br>female   |  | 4. RACE<br>black |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>10 8 81   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>YRS. MONTHS DAYS<br>4 |  | 7. IF UNDER 1 YR.<br>MONTHS DAYS<br>HOURS MIN.  |  | 2c. DATE PRONOUNCED DEAD<br>MONTH DAY YEAR<br>2 27 82          |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MD  |  |                  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |  |  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore   |  |                  |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>71 S. Morley Street |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)   |  |  |  |
| 13a. STATE<br>MD   |  |                  |  | 13b. CITY OR TOWN<br>Baltimore  |  |  |  | 13c. STREET ADDRESS<br>71 S. Morley Avenue  |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Thomas Timpson   |  |                  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Tara Mack  |  |  |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br>No  |  |                  |  | 16b. SOCIAL SECURITY NO.<br>N/A.  |  |  |  | 17. INFORMANT ADDRESS<br>Tara Mack 71 S. Morley Avenue  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)).<br>PART I DEATH WAS CAUSED BY:<br>7980 IMMEDIATE CAUSE (a) Sudden Infant Death Syndrome<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.   |  |                  |  |   |  |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                   |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I a.  |  |                  |  |   |  |  |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  |                  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  |  |  | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |  |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  |                  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |  |  |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |                  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)   |  |  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |  |                  |  |   |  |  |  |   |  |  |  |
| ACTUAL SIGNATURE<br>Hormez R. Guard, M.D.  |  |                  |  | TITLE (SPECIFY)<br>M.D. Assistant MEDICAL EXAMINER  |  |  |  | DATE SIGNED<br>2/27/82  |  |  |  |
| EXAMINER'S NAME (TYPE OR PRINT)<br>Hormez R. Guard, M.D.   |  |                  |  | ADDRESS<br>111 Penn Street, Balto. MD 21201   |  |  |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial   |  |                  |  | 23b. DATE<br>3/3/82   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Church Cemetery    |  |   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Frederick MD     |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Wm. C. March F/H ADDRESS<br>1101 E. North Ave.   |  |                  |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br>MAR 1 1982              |  | 25b. REGISTRAR'S SIGNATURE<br>Charles Jan Nathan  |  |  |  |



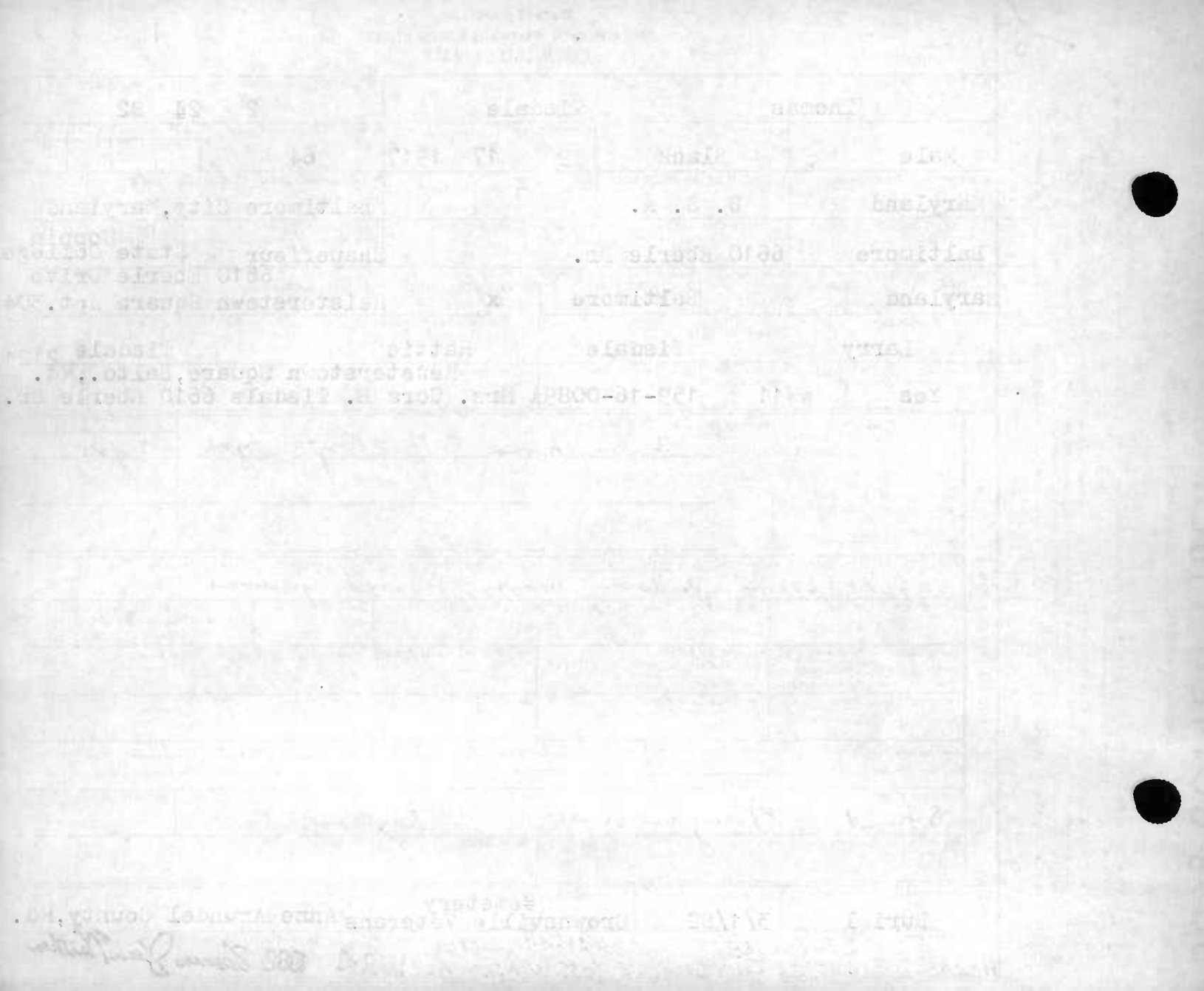
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the Registrar of the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  | 8 2 0 4 2 5 9   |  |  |  |
|---|--|---|--|---|--|--|--|
| FOR<br>1. STATE REGISTRAR   |  |   |  | REG. NO.  |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>Thomas Tisdale</b>   |  |   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>2 24 82</b>   |  | 2b. HOUR<br>M<br><b>M</b>  |  |
| 3. SEX<br><b>Male</b>   |  | 4. RACE<br><b>Black</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>9 17 1917</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>YRS<br><b>64</b>  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City, Maryland, MD</b>  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>6610 Eberle Dr.</b> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Chauffeur</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Coppin State College</b>   |  |
| 13a. STATE<br><b>Maryland</b>   |  | 13b. COUNTY<br><b>Baltimore</b>   |  | 13c. CITY OR TOWN<br><b>Baltimore</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Larry Tisdale</b>  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Hattie Tisdale</b>  |  | 16. REISTERSTOWN ADDRESS<br><b>Reisterstown Square Apt. 304</b>   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>Yes</b>  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>WW11</b>  |  | 17. INFORMANT<br><b>Mrs. Cora E. Tisdale</b>  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br><b>2000</b> IMMEDIATE CAUSE (a) <b>Lymphoma, Histiocytic type</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>3 yrs</b>  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a<br><b>Cord Lesion producing Brown - Sequard Syndrome</b>   |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>Dec. 7, 19 79</b> to <b>Nov. 4, 19 81</b> , that (I) (we) lost<br>saw the deceased alive on <b>19</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.                                     |  |   |  |   |  |  |  |
| 22b. SIGNATURE<br><b>Stunt H. M. Rogers MD</b>  |  |   |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>        |  | 22c. DATE SIGNED   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  |   |  | 22e. ADDRESS  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>3/1/82</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Crownsville Veterans Cemetery</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Anne Arundel County, Md.</b>  |  |
| 24. FUNERAL DIRECTOR<br>NAME <b>BALTIMORE</b> ADDRESS <b>MARYLAND 21211</b>   |  |   |  | 25a. DATE REC'D. BY REGISTRAR <b>MAR 1 1982</b> 25b. REGISTRAR'S SIGNATURE <b>Thomas J. Nathan</b>  |  |  |  |
| 26. FUNERAL HOME <b>HEBERT E. NUTTER FUNERAL HOME 3035 W. NORTH AVE</b>   |  |   |  |   |  |  |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  |   | 8 2 0 4 2 6 0   |   |  |  |
|---|--|--|--|---|---|---|--|--|
| 1. FOR STATE REGISTRAR  |  |  |  |   | REG NO.   |   |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br><b>Robert Lee (B.B.) Titus III</b>   |  |  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>2 9 82</b>                      |   |  | 2b. HOUR<br><b>10:15pm</b>                   |
| 3 SEX<br><b>MALE</b>  |  | 4 RACE<br><b>NEGRO</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>1 10 82</b>  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>YRS MONTHS DAYS<br><b>1 31</b>     |  | IF UNDER 1 YEAR<br>IF UNDER 24 HRS.          |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>M.D.</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Balto City</b> MD.         |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Sinai Hospital</b> |  |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)          |   | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13a. STATE<br><b>MD</b>   |  |  |  |   | 13b. CITY OR TOWN<br><b>BALTIMORE</b>                                     |   | 13c. STREET ADDRESS<br><b>1300 N. LONGWOOD ST</b>  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Robert Lee Titus Jr.</b>   |  |  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>PAMELA - Hall</b>     |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>   |  |  |  |   | 16b. SOCIAL SECURITY NO.<br><b>N/A</b>                                    |   | 17. INFORMANT<br>ADDRESS <b>1300 N. Longwood St.</b><br><b>MR. &amp; MRS. Robert Lee Titus Jr.</b>                         |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiorespiratory arrest</b><br><b>7678</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>red intracranial pressure</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(c) <b>Intraventricular haem. &amp; hydrocephalus</b> |  |  |  |   |   |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)<br><b>Prematurity, Klebsiella pneumoniae Sepsis, Resp. distress Synd.</b>   |  |  |  |   |   |   |  |  |
| 19a. DATE OF OPERATION<br><b>1.20.82</b>  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>Patent Ductus arteriosus</b>  |  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |   |   |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |   |  |  |
| 22a. I certify that <del>he</del> (this hospital) attended the deceased from <b>1. 10</b> , 19 <b>82</b> , to <b>2. 9.</b> 19 <b>82</b> , that (I) (we) lost<br>saw the deceased alive on <b>2. 9</b> 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.                                    |  |  |  |   |   |   |  |  |
| 22b. SIGNATURE<br><b>N. Verma</b>   |  |  |  |   | DEGREE<br><b>MD</b>   |   | 22c. DATE SIGNED<br><b>2.9.82</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>NIRUPMA VERMA</b>   |  |  |  |   | 22e. ADDRESS<br><b>SINAI HOSP OF BALTIMORE</b>                            |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>2/12/82</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Cedar Hill Cem.</b>  |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Co. MD</b> |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Wm. C. March F/H 1101 E. North Ave.</b>  |  |  |  |   | 25a. DATE REC'D. BY REGISTRAR<br><b>FEB 16 1982</b>                       |   | 25b. REGISTRAR'S SIGNATURE<br><i>Thomas J. Nathan</i>  |  |



0755

C: M

 $\pi \approx 3.14$ 

Report

25-4

57A

10. *Chlorophyll a* and *Chlorophyll b* content of the leaves was determined by the method of Arnon and Whistler (1940).

General 01/15/82 (Copy Hill Co. - Baltimore Co. MD)

U.S. C. March 7/91 H/7 Noam S. Levy



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 4 2 6 1

REG. NO.

|  |   |   |   |   |  |
|--|---|---|---|---|--|
| 1 DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST <b>MARIE</b> MIDDLE <b>LOUISE</b> LAST <b>TONER</b><br><b>MARIE TONER</b>  |   |   | 2a. DATE OF DEATH<br>MONTH <b>02</b> DAY <b>18</b> YEAR <b>82</b><br><b>12:40 PM</b>                |   |  |
| 3 SEX<br><b>Female</b>   | 4 RACE<br><b>Cauc.</b>  | 5. DATE OF BIRTH<br>MONTH <b>5</b> DAY <b>16</b> YEAR <b>1904</b>   | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>78-77</b> YRS.   |   |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>        | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City, MD</b>                                    |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>The Good Samaritan H.</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>School Teacher-Education</b> |   | 12b. KIND OF BUSINESS OR INDUSTRY  |
| 13a. STATE<br><b>Maryland</b>  |   | 13b. COUNTY<br><b>Baltimore</b>   | 13c. CITY OR TOWN<br><b>Baltimore</b>   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS<br><b>3909 Rokeby Road 21229</b>   |
| 14 FATHER'S NAME<br>FIRST <b>Harry</b> MIDDLE <b>Convery</b> LAST <b>Convery</b>   |   |   | 15 MOTHER'S MAIDEN NAME<br>FIRST <b>Josephine</b> MIDDLE <b>Tschudy</b> LAST <b>Tschudy</b>         |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>no</b>  |   | 16b. SOCIAL SECURITY NO.<br><b>214-34-2688</b>  | 17 INFORMANT<br>ADDRESS<br><b>Freeland, Md. 21053</b><br><b>John G. Toner, 21416 N. Ruhl Rd.</b>    |   |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Extensive Myocardial infarction</b><br><b>4100</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) <b>Pulmonary Edema</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Hypotension and Acute tubular necrosis</b> |   |   |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)<br><b>Rheumatoid arthritis - Hypothyroidism</b>   |   |   |   |   |  |
| 19a. DATE OF OPERATION   |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)                   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>02/15</b> , 19 <b>82</b> , to <b>02/18</b> , 19 <b>82</b> , that (I) (we) lost<br>saw the deceased alive on <b>2/18</b> , 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.   |   |   |   |   |  |
| 22b. SIGNATURE<br><b>Zaglama</b>   |   | DEGREE<br><b>MD</b><br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |   | 22c. DATE SIGNED<br><b>2/18/82</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>NABIL ZAGLAMA MD</b>   |   | 22e. ADDRESS<br><b>The Good Samaritan Hosp.</b>   |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  | 23b. DATE<br><b>2/22/82</b>   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Lorraine Park Cem</b>  |   | 23d. LOCATION<br>CITY OR TOWN <b>Baltimore</b> COUNTY <b>MD</b> STATE                           |  |
| 24 FUNERAL DIRECTOR<br>NAME <b>1630 Edmondson Ave., Catonsville</b><br><b>Witzke Catonsville Funeral Home, P.A.</b>  |   | DATE REC'D. BY REGISTRAR'S SIGNATURE<br><b>FEB 22 1982</b><br><b>James J. [Signature]</b>   |   |   |  |

MEDICAL CERTIFICATION

2  
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |   |  |  |  |  |  | 8 2 0 4 2 6 2   |  |
|--|--|--|--|---|--|--|--|--|--|---|--|
| 1. FOR<br>STATE<br>REGISTRAR   |  | REG. NO.   |  |   |  |  |  |  |  |   |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>EDNA C. TOPPING   |  |  |  |   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>2 20 82   |  | 2b. HOUR<br>9 04 A.M.  |  |   |  |
| 1. SEX<br>Female   |  | 4. RACE<br>White   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>3 23 044  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>77 YRS.   |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS  |  | 8. IF UNDER 24 HRS.<br>HOURS MIN.   |  |
| 7a. BIRTHPLACE<br>Maryland   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD  |  |  |  |   |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>University of Maryland Hospital |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Homemaker  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |   |  |
| 13a. STATE<br>Maryland   |  |  |  |   |  | 13b. COUNTY<br>Baltimore   |  | 13c. CITY OR TOWN<br>Woodlawn  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>William Charles Taylor   |  |  |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Carrie Bishop   |  |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>NO   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>213-05-7946   |  | 17. INFORMANT<br>William E. Topping, Jr.  |  | ADDRESS<br>5505 W. North Avenue 21207  |  |  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Sepsis Shock</u><br>5715<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Spontaneous Bacterial Peritonitis</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>Cirrhosis of the Liver</u> |  |  |  |   |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>12 hrs.<br>24 hrs.<br>1 yr.                     |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)<br><u>Congestive Heart Failure</u>  |  |  |  |   |  |  |  |  |  |   |  |
| 19a. DATE OF OPERATION<br>Jan 1, 1982  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br>Possible Abdominal Abscess   |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |  |  |  |  |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>12/1/81</u> 19 <u>81</u> to <u>2/20</u> 19 <u>82</u> , that (I) (we) last saw the deceased alive on <u>2/20</u> 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.  |  |  |  |   |  |  |  |  |  |   |  |
| 22b. SIGNATURE<br>Beth Hewitt  |  |  |  |   |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br>2/20/82  |  |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Beth Hewitt   |  |  |  |   |  | 22e. ADDRESS<br>U. of Maryland Hospital  |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial   |  | 23b. DATE<br>2/24/82   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Loudon Park Cemetery  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore Maryland   |  |  |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Hubbard Funeral Home, Inc.   |  |  |  |   |  | ADDRESS<br>21229<br>4107 Wilkens Ave.  |  | 25a. DATE REC'D. BY REGISTRAR<br>FEB 22 1982   |  | 25b. REGISTRAR'S SIGNATURE<br>[Signature]   |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 4 2 6 3

REG. NO.

|   |  |  |  |  |  |
|---|--|--|--|--|--|
| 1 DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>Harvey L. Torrence</b>  |  |  | 2a DATE OF DEATH<br>MONTH DAY YEAR<br><b>2 19 1982</b>   |  | 2b HOUR<br>M<br><b></b>                                      |
| 3 SEX<br><b>male</b>  | 4 RACE<br><b>black</b>   | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br><b>12 11 1922</b>   |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>59</b> YRS.   | IF UNDER 1 YEAR<br>MONTHS DAYS<br><b></b>                    |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>N.C.</b>   | 7b CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore city</b> MD.                         |  |
| 10 CITY OR TOWN OF DEATH<br><b>Baltimore</b>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>1 N. Abington Avenue</b> |  |  | 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b></b>               |  |
| 12b KIND OF BUSINESS OR INDUSTRY<br><b></b>   |  |  |  |  |  |
| 13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>STATE<br><b>Md</b>   | 13b COUNTY<br><b>Baltimore</b>   | 13c CITY OR TOWN<br><b>Baltimore</b>   | 13d INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e STREET ADDRESS<br><b>1 N. Abington Avenue</b>  |  |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Unknown</b>   |  |  | 15 MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Margaret Torrence</b>                       |  |  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>Yes</b>   |  | 16b SOCIAL SECURITY NO.<br><b>237-24-0462</b>  |  | 17 INFORMANT<br>ADDRESS<br><b>Varie E. Torrence 1 N. Abington Ave</b>                    |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardio pulmonary arrest</b><br><b>1629</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost<br>(b) <b>eat cell carcinoma lung</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b></b> |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>1 yr.</b> |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |  |  |  |  |
| 19a DATE OF OPERATION<br><b>9 9</b>   |  | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b></b>   |  | 20a AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                 |  |
| 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |  |  |  |  |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)<br><b></b> |  |
| 21d INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)<br><b></b>   |  | 21f LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br><b></b>                              |  |
| 22a I certify that (I) (this hospital) attended the deceased from <b>Feb. 16</b> , 19 <b>82</b> , to <b>Feb 18</b> , 19 <b>82</b> , that (I) (we) lost<br>saw the deceased alive on <b>Feb. 18</b> , 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.                         |  |  |  |  |  |
| 22b SIGNATURE<br><b>Jan Laws Houghton MD</b><br>DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>  |  |  |  | 22c DATE SIGNED<br><b>2/24/82</b>  |  |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Jan Laws Houghton</b>  |  |  | 22e ADDRESS<br><b>Loch Raven U.A. Hospital</b>   |  |  |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |  | 23b DATE<br><b>2/24/82</b>   |  | 23c NAME OF CEMETERY OR CREMATORY<br><b>Md Veteran Cemetery Crownsville</b>              |  |
| 23d LOCATION<br>CITY OR TOWN COUNTY STATE<br><b></b>  |  | 24 FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>William C. March F/h 1101 E. North Ave</b>   |  |  |  |
| 25a DATE REC'D. BY REGISTRAR<br><b>FEB 23 1982</b>  |  |  |  | 25b REGISTRAR'S SIGNATURE<br><b>Jan Laws Houghton</b>                                    |  |

1863



Received of the Secretary of the Army  
the sum of \$100.00

For the purchase of  
the sum of \$100.00  
for the purchase of  
the sum of \$100.00

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Persons may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| 1. DECEASED NAME   |   | 2a. DATE OF DEATH   |                                      | 2b. HOUR  |  |
|--|---|---|--------------------------------------|---|--|
| FIRST  | MIDDLE  | MONTH   | DAY                                  | YEAR  | MIN.   |
| IRMA   | TORRENCE  | 2/20/82   |                                      |   | 11:45 AM                                     |
| 3. SEX   | 4. RACE   | 5. DATE OF BIRTH  | 6. AGE                               |   |  |
| FEMALE   | White   | April 16, 1894  | 87                                   | 97  |  |
| 7a. BIRTHPLACE   | 7b. CITIZEN OF WHAT COUNTRY?                            | 8. MARRIED  | 9. BALTIMORE CITY OR COUNTY OF DEATH |   |  |
| Maryland   | U.S.A.  | NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | Baltimore City MD.                   |   |  |
| 10. CITY OR TOWN OF DEATH  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION |   | 12a. USUAL OCCUPATION                |   |  |
| Baltimore  | Belair Convalescent Center                              |   | Candy Production                     |   |  |
| 13a. STATE   |   |   |                                      |   |  |
| Maryland   |   |   |                                      |   |  |
| 13b. COUNTY  |   | 13c. CITY OR TOWN   |                                      | 13d. INSIDE CITY LIMITS?  |  |
|  |   | Baltimore   |                                      | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 14. FATHER'S NAME  |   | 15. MOTHER'S MAIDEN NAME  |                                      |   |  |
| Charles Hopkins  |   | Sally Gardner   |                                      |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?   |   | 16b. SOCIAL SECURITY NO.  |                                      | 17. INFORMANT   |  |
| No   |   | 212-09-9825   |                                      | Daughter: White Marsh, Md.  |  |
|  |   |   |                                      | Norma J. Barrett 9708 Gaylord St. 21162                             |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |   |   |                                      |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART I. DEATH WAS CAUSED BY:   |   |   |                                      |   |  |
| IMMEDIATE CAUSE (a) <u>HEAVY-ANGINAL CHF</u>   |   |   |                                      |   |  |
| DUE TO, OR AS A CONSEQUENCE OF (b) <u>DILATED MYOCARDIUM - MYOCARDIAL INFARCTION</u>   |   |   |                                      |   |  |
| DUE TO, OR AS A CONSEQUENCE OF (c) <u>DEPENDENT</u>  |   |   |                                      |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |   |   |                                      |   |  |
| 19a. DATE OF OPERATION   |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |                                      | 20a. AUTOPSY?   |  |
|  |   |   |                                      | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |   | 21b. TIME OF INJURY   |                                      | 21c. HOW INJURY OCCURRED  |  |
| (If either, notify medical examiner)   |   | HOUR A.M. MONTH DAY YEAR  |                                      | (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)               |  |
|  |   | P.M. 19   |                                      |   |  |
| 21d. INJURY OCCURRED   |   | 21e. PLACE OF INJURY  |                                      | 21f. LOCATION   |  |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>   |   | (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |                                      | STREET CITY OR TOWN COUNTY STATE                                    |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>2/15/82</u> to <u>FEB 21 1982</u> , that (I) (we) lost saw the deceased alive on <u>2/15/82</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |   |   |                                      |   |  |
| 22b. SIGNATURE   |   | 22c. DATE SIGNED  |                                      | 22d. ADDRESS  |  |
| <u>Don W. Minter MD.</u>   |   | 2/20/82   |                                      | 3009 EVERGREEN AVE BALTIMORE MD.                                    |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |   | 23b. DATE   |                                      | 23c. NAME OF CEMETERY OR CREMATORY                                  |  |
| Burial   |   | Feb 23 1982   |                                      | Loudon Park Cem.  |  |
| 24. FUNERAL DIRECTOR   |   | 25a. DATE REC'D. BY REGISTRAR   |                                      | 25b. REGISTRAR'S SIGNATURE  |  |
| NAME Leonard J. Ruck, Inc.   |   | FEB 22 1982   |                                      | Frances Van Natten  |  |
| ADDRESS Baltimore, Maryland  |   |   |                                      |   |  |





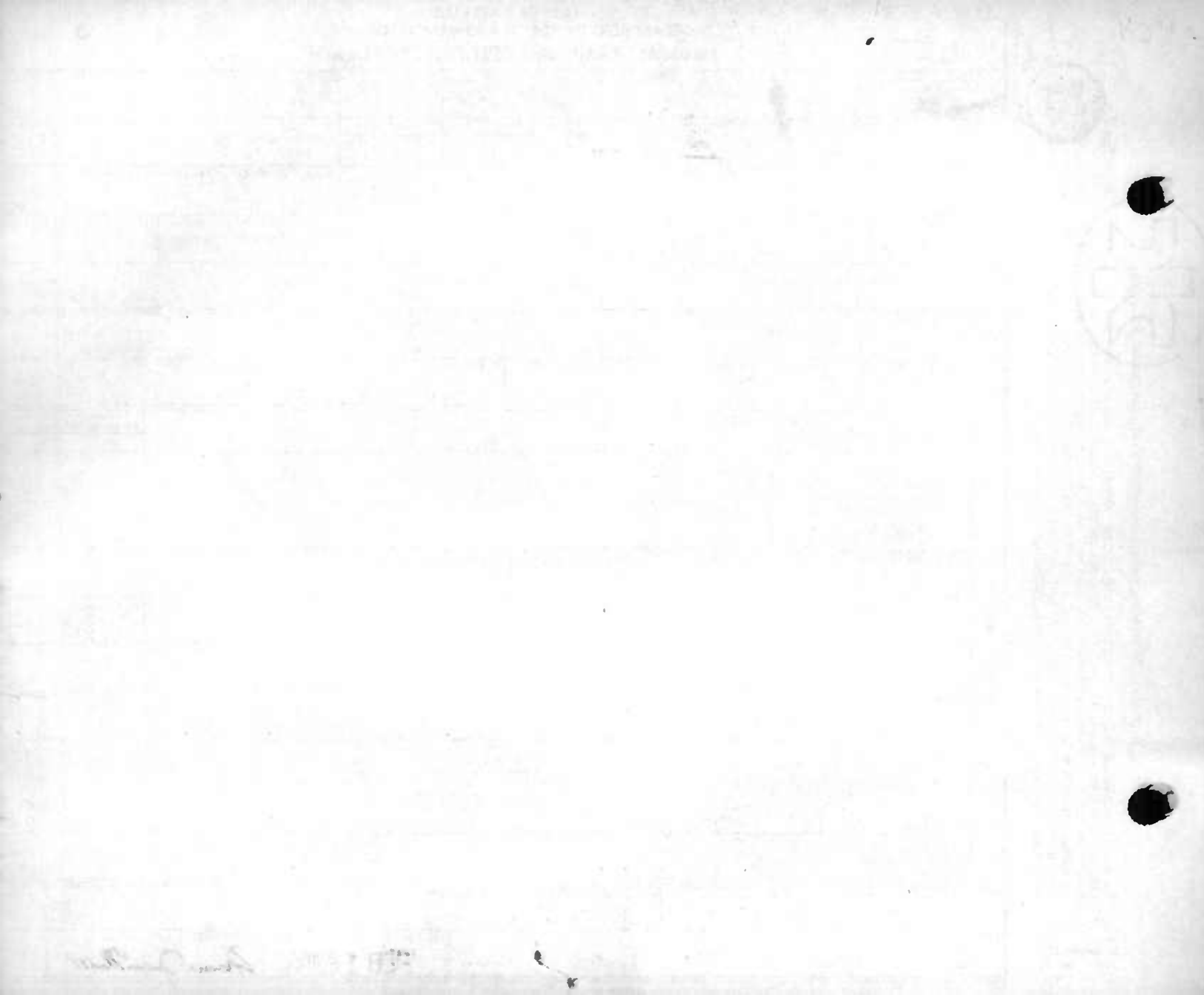
TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, WRITE IN PENCIL IN ITEM 18, "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGE 4 TO THE FUNERAL DIRECTOR. GIVE PAGE 5 TO THE CHIEF MEDICAL EXAMINER. ALONG WITH FORM PM-3, RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

Items #5&amp; Film G565 3/30/82 re

FOR Item 5 g566 4/20/82  
1- STATE REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |   |  |  |  |   |  |                     |  |                                       |  |                    |  |                    |  |                    |  |                    |  |
|---|--|--|--|---|--|--|--|---|--|---------------------|--|---------------------------------------|--|--------------------|--|--------------------|--|--------------------|--|--------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  | FIRST  |  | MIDDLE  |  | LAST   |  | 2a. DATE KNOWN OF DEATH   |  | MONTH               |  | DAY                                   |  | YEAR               |  | 2b. HOUR           |  |                    |  |                    |  |
| JESSE   |  | L.   |  |   |  | TOWNES (TOWNS) JR.   |  | 2   |  | 12                  |  | 19                                    |  | 82                 |  | M                  |  |                    |  |                    |  |
| 3. SEX  |  | 4. RACE  |  | 5. DATE OF BIRTH  |  | 6. AGE (IN YEARS)  |  | 7. IF UNDER 1 YR.   |  | 8. IF UNDER 24 HRS. |  | 9. DATE PRONOUNCED DEAD               |  | MONTH              |  | DAY                |  | YEAR               |  | 2d. HOUR           |  |
| male  |  | negro  |  | 10 27 48  |  | 43 YRS.  |  | MONTHS  |  | DAYS                |  | HOURS                                 |  | MIN.               |  | 2                  |  | 12                 |  | 19 82              |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED  |  | 9. NEVER MARRIED   |  | 10. WIDOWED   |  | 11. DIVORCED        |  | 12. BALTIMORE CITY OR COUNTY OF DEATH |  | 13. BALTIMORE CITY |  | 14. MD.            |  | 15. BALTIMORE CITY |  | 16. MD.            |  |
| S.C.  |  | USA  |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION                      |  | 12. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) |  | 13. KIND OF BUSINESS OR INDUSTRY                                    |  | 14. BALTIMORE CITY  |  | 15. BALTIMORE CITY                    |  | 16. BALTIMORE CITY |  | 17. BALTIMORE CITY |  | 18. BALTIMORE CITY |  | 19. BALTIMORE CITY |  |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION   |  | 12. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                  |  | 13. KIND OF BUSINESS OR INDUSTRY                             |  | 14. BALTIMORE CITY  |  | 15. BALTIMORE CITY  |  | 16. BALTIMORE CITY                    |  | 17. BALTIMORE CITY |  | 18. BALTIMORE CITY |  | 19. BALTIMORE CITY |  | 20. BALTIMORE CITY |  |
| Baltimore   |  | University Hospital  |  | 12. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                  |  | 13. KIND OF BUSINESS OR INDUSTRY                             |  | 14. BALTIMORE CITY  |  | 15. BALTIMORE CITY  |  | 16. BALTIMORE CITY                    |  | 17. BALTIMORE CITY |  | 18. BALTIMORE CITY |  | 19. BALTIMORE CITY |  | 20. BALTIMORE CITY |  |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  | 13a. STATE   |  | 13b. COUNTY   |  | 13c. CITY OR TOWN  |  | 13d. INSIDE CITY LIMITS?  |  | 13e. STREET ADDRESS |  | 14. BALTIMORE CITY                    |  | 15. BALTIMORE CITY |  | 16. BALTIMORE CITY |  | 17. BALTIMORE CITY |  | 18. BALTIMORE CITY |  |
| MD  |  |  |  |   |  | Baltimore  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 3127 Mareco Avenue  |  | 14. BALTIMORE CITY                    |  | 15. BALTIMORE CITY |  | 16. BALTIMORE CITY |  | 17. BALTIMORE CITY |  | 18. BALTIMORE CITY |  |
| 14. FATHER'S NAME   |  | 15. MOTHER'S MAIDEN NAME   |  | 16. BALTIMORE CITY  |  | 17. BALTIMORE CITY   |  | 18. BALTIMORE CITY  |  | 19. BALTIMORE CITY  |  | 20. BALTIMORE CITY                    |  | 21. BALTIMORE CITY |  | 22. BALTIMORE CITY |  | 23. BALTIMORE CITY |  | 24. BALTIMORE CITY |  |
| Jesse L. Townes   |  | Betty Moore  |  | 16. BALTIMORE CITY  |  | 17. BALTIMORE CITY   |  | 18. BALTIMORE CITY  |  | 19. BALTIMORE CITY  |  | 20. BALTIMORE CITY                    |  | 21. BALTIMORE CITY |  | 22. BALTIMORE CITY |  | 23. BALTIMORE CITY |  | 24. BALTIMORE CITY |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)  |  | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT   |  | 18. ADDRESS  |  | 19. BALTIMORE CITY  |  | 20. BALTIMORE CITY  |  | 21. BALTIMORE CITY                    |  | 22. BALTIMORE CITY |  | 23. BALTIMORE CITY |  | 24. BALTIMORE CITY |  | 25. BALTIMORE CITY |  |
| Yes   |  | 219-50-2812  |  | Betty Townes  |  | 3127 Mareco Ave.   |  | 19. BALTIMORE CITY  |  | 20. BALTIMORE CITY  |  | 21. BALTIMORE CITY                    |  | 22. BALTIMORE CITY |  | 23. BALTIMORE CITY |  | 24. BALTIMORE CITY |  | 25. BALTIMORE CITY |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |  | 19. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  | 20. BALTIMORE CITY  |  | 21. BALTIMORE CITY   |  | 22. BALTIMORE CITY  |  | 23. BALTIMORE CITY  |  | 24. BALTIMORE CITY                    |  | 25. BALTIMORE CITY |  | 26. BALTIMORE CITY |  | 27. BALTIMORE CITY |  | 28. BALTIMORE CITY |  |
| PART I DEATH WAS CAUSED BY:   |  | IMMEDIATE CAUSE (a)  |  | Blunt force head trauma   |  | DUE TO, OR AS A CONSEQUENCE OF                               |  | 20. BALTIMORE CITY  |  | 21. BALTIMORE CITY  |  | 22. BALTIMORE CITY                    |  | 23. BALTIMORE CITY |  | 24. BALTIMORE CITY |  | 25. BALTIMORE CITY |  | 26. BALTIMORE CITY |  |
| 9682  |  | DUE TO, OR AS A CONSEQUENCE OF   |  | 20. BALTIMORE CITY  |  | 21. BALTIMORE CITY   |  | 22. BALTIMORE CITY  |  | 23. BALTIMORE CITY  |  | 24. BALTIMORE CITY                    |  | 25. BALTIMORE CITY |  | 26. BALTIMORE CITY |  | 27. BALTIMORE CITY |  | 28. BALTIMORE CITY |  |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.   |  | DUE TO, OR AS A CONSEQUENCE OF   |  | 20. BALTIMORE CITY  |  | 21. BALTIMORE CITY   |  | 22. BALTIMORE CITY  |  | 23. BALTIMORE CITY  |  | 24. BALTIMORE CITY                    |  | 25. BALTIMORE CITY |  | 26. BALTIMORE CITY |  | 27. BALTIMORE CITY |  | 28. BALTIMORE CITY |  |
| (b)   |  | DUE TO, OR AS A CONSEQUENCE OF   |  | 20. BALTIMORE CITY  |  | 21. BALTIMORE CITY   |  | 22. BALTIMORE CITY  |  | 23. BALTIMORE CITY  |  | 24. BALTIMORE CITY                    |  | 25. BALTIMORE CITY |  | 26. BALTIMORE CITY |  | 27. BALTIMORE CITY |  | 28. BALTIMORE CITY |  |
| (c)   |  | DUE TO, OR AS A CONSEQUENCE OF   |  | 20. BALTIMORE CITY  |  | 21. BALTIMORE CITY   |  | 22. BALTIMORE CITY  |  | 23. BALTIMORE CITY  |  | 24. BALTIMORE CITY                    |  | 25. BALTIMORE CITY |  | 26. BALTIMORE CITY |  | 27. BALTIMORE CITY |  | 28. BALTIMORE CITY |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  | 20. BALTIMORE CITY   |  | 21. BALTIMORE CITY  |  | 22. BALTIMORE CITY   |  | 23. BALTIMORE CITY  |  | 24. BALTIMORE CITY  |  | 25. BALTIMORE CITY                    |  | 26. BALTIMORE CITY |  | 27. BALTIMORE CITY |  | 28. BALTIMORE CITY |  | 29. BALTIMORE CITY |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  | 20. BALTIMORE CITY  |  | 21. BALTIMORE CITY   |  | 22. BALTIMORE CITY  |  | 23. BALTIMORE CITY  |  | 24. BALTIMORE CITY                    |  | 25. BALTIMORE CITY |  | 26. BALTIMORE CITY |  | 27. BALTIMORE CITY |  | 28. BALTIMORE CITY |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  | 20. BALTIMORE CITY  |  | 21. BALTIMORE CITY   |  | 22. BALTIMORE CITY  |  | 23. BALTIMORE CITY  |  | 24. BALTIMORE CITY                    |  | 25. BALTIMORE CITY |  | 26. BALTIMORE CITY |  | 27. BALTIMORE CITY |  | 28. BALTIMORE CITY |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  | 21b. TIME OF INJURY  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |  | 22. BALTIMORE CITY   |  | 23. BALTIMORE CITY  |  | 24. BALTIMORE CITY  |  | 25. BALTIMORE CITY                    |  | 26. BALTIMORE CITY |  | 27. BALTIMORE CITY |  | 28. BALTIMORE CITY |  | 29. BALTIMORE CITY |  |
| 8:20 P.M. 2-11-1982   |  | Subject struck on head.  |  | 22. BALTIMORE CITY  |  | 23. BALTIMORE CITY   |  | 24. BALTIMORE CITY  |  | 25. BALTIMORE CITY  |  | 26. BALTIMORE CITY                    |  | 27. BALTIMORE CITY |  | 28. BALTIMORE CITY |  | 29. BALTIMORE CITY |  | 30. BALTIMORE CITY |  |
| 21d. INJURY OCCURRED  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)  |  | 21f. LOCATION   |  | 22. BALTIMORE CITY   |  | 23. BALTIMORE CITY  |  | 24. BALTIMORE CITY  |  | 25. BALTIMORE CITY                    |  | 26. BALTIMORE CITY |  | 27. BALTIMORE CITY |  | 28. BALTIMORE CITY |  | 29. BALTIMORE CITY |  |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>  |  | street   |  | 2100 blk. Frederick Ave., Balto.  |  | 22. BALTIMORE CITY   |  | 23. BALTIMORE CITY  |  | 24. BALTIMORE CITY  |  | 25. BALTIMORE CITY                    |  | 26. BALTIMORE CITY |  | 27. BALTIMORE CITY |  | 28. BALTIMORE CITY |  | 29. BALTIMORE CITY |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: |  | Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> |  | TITLE (SPECIFY)   |  | M.D. Assistant   |  | MEDICAL EXAMINER  |  | DATE SIGNED         |  | 2-12-82                               |  | 23. BALTIMORE CITY |  | 24. BALTIMORE CITY |  | 25. BALTIMORE CITY |  | 26. BALTIMORE CITY |  |
| ACTUAL SIGNATURE  |  | Ann M. Dixon, M.D.   |  | 111 Penn St.  |  | 23. BALTIMORE CITY   |  | 24. BALTIMORE CITY  |  | 25. BALTIMORE CITY  |  | 26. BALTIMORE CITY                    |  | 27. BALTIMORE CITY |  | 28. BALTIMORE CITY |  | 29. BALTIMORE CITY |  | 30. BALTIMORE CITY |  |
| EXAMINER'S NAME (TYPE OR PRINT)   |  | 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  | 23b. DATE   |  | 23c. NAME OF CEMETERY OR CREMATORY                           |  | 23d. LOCATION   |  | 24. BALTIMORE CITY  |  | 25. BALTIMORE CITY                    |  | 26. BALTIMORE CITY |  | 27. BALTIMORE CITY |  | 28. BALTIMORE CITY |  | 29. BALTIMORE CITY |  |
| Burial  |  | 2/18/82  |  | Md. Veteran Cem.  |  | Crownsville  |  | 24. BALTIMORE CITY  |  | 25. BALTIMORE CITY  |  | 26. BALTIMORE CITY                    |  | 27. BALTIMORE CITY |  | 28. BALTIMORE CITY |  | 29. BALTIMORE CITY |  | 30. BALTIMORE CITY |  |
| 24. FUNERAL DIRECTOR  |  | 25a. DATE REC'D. BY REGISTRAR  |  | 25b. REGISTRAR'S SIGNATURE  |  | 26. BALTIMORE CITY   |  | 27. BALTIMORE CITY  |  | 28. BALTIMORE CITY  |  | 29. BALTIMORE CITY                    |  | 30. BALTIMORE CITY |  | 31. BALTIMORE CITY |  | 32. BALTIMORE CITY |  | 33. BALTIMORE CITY |  |
| Wm. C. March F/H  |  | 1101 E. North Ave.   |  | FEB 16 1982   |  | Name Jan North   |  | 26. BALTIMORE CITY  |  | 27. BALTIMORE CITY  |  | 28. BALTIMORE CITY                    |  | 29. BALTIMORE CITY |  | 30. BALTIMORE CITY |  | 31. BALTIMORE CITY |  | 32. BALTIMORE CITY |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal with the State Dept. of Health and Mental Hygiene. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |  |  |   |  |  |  |  |  |
|--|--|--|--|---|--|--|--|--|--|
| 1 - FOR STATE REGISTRAR  |  |  |  |   |  |  |  |  |  |
| CERTIFICATE OF DEATH   |  |  |  |   |  |  |  |  |  |
| REG. NO.   |  |  |  |   |  |  |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br>AMY LYNN Travis  |  |  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>02 24 82  |  | 2b. HOUR<br>3:15 P.M.                          |  |  |
| 3. SEX<br>Female   |  | 4. RACE<br>White   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>02 15 82  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>9 days                                  |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS<br>0 9   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MARYLAND  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.                 |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Baltimore City Hospital |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Infant |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>Maryland   |  |  |  |   | 13b. CITY OR TOWN<br>Wicomico  |  | 13c. STREET ADDRESS<br>107 W. Philadelphia Ave |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>(unknown)  |  |  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Edith Travis  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>NO   |  | 16b. SOCIAL SECURITY NO.<br>—  |  | 17. INFORMANT<br>ADDRESS<br>Mrs. Edith Travis (mother) same as 13   |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) Cardiorespiratory collapse<br>7712<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) Probable central nervous system, liver kidney failure<br>24-36 hours<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) Neonatal Herpes virus infection<br>9 days |  |  |  |   |  |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)<br>None  |  |  |  |   |  |  |  |  |  |
| 19a. DATE OF OPERATION<br>None   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br>—  |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. — 19 —   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)<br>—   |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)<br>—  |  | 21f. LOCATION<br>STREET<br>—  |  | CITY OR TOWN<br>—  |  | COUNTY<br>—  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 02-19, 19 82, to 02-24, 19 82, that (I) (we) lost saw the deceased alive on 02-24, 19 82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.  |  |  |  |   |  |  |  |  |  |
| 22b. SIGNATURE<br>Karen D. Crissinger, MD  |  |  |  |   | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  |  | 22c. DATE SIGNED<br>2/24/82  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Karen D. Crissinger   |  |  |  |   | 22e. ADDRESS<br>205 Wendover Rd Baltimore Md 21248   |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial  |  | 23b. DATE<br>3/1/82  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Wicomico Memorial Park  |  | 23d. LOCATION<br>CITY OR TOWN<br>Salisbury, Wicomico, Maryland             |  | STATE  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>HOLLOWAY FUNERAL HOME, Salisbury, Maryland   |  |  |  |   | 25a. DATE REC'D. BY REGISTRAR<br>MAR 3 1982  |  |  |  |  |
| 25b. REGISTRAR'S SIGNATURE<br>[Signature]  |  |  |  |   |  |  |  |  |  |

WATER RIGHTS  
DIVISION  
SALT LAKE CITY  
UTAH

WATER RIGHTS  
DIVISION  
SALT LAKE CITY  
UTAH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |  |  | 8 2 0 4 2 6 7   |  |  |   |
|--|--|--|--|---|--|--|---|
| 1- FOR STATE REGISTRAR   |  |  |  | REG. NO.  |  |  |   |
| 1. DECEASED NAME (TYPE OR PRINT)<br><b>RUBY E Maye TRAYNOR</b>   |  |  |  | 2a. DATE OF DEATH<br><b>FEBRUARY 12 82</b>  |  | 2b. HOUR<br><b>6 15 A M</b>  |   |
| 3. SEX<br><b>Female</b>  |  | 4. RACE<br><b>White</b>  |  | 5. DATE OF BIRTH<br>MONTH <b>Feb.</b> DAY <b>15,</b> YEAR <b>1928</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>53</b> YRS.  |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Texas</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTO. CITY, MD.</b>  |   |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>UNION MEMORIAL HOSPITAL</b> |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Sceretary State</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Roads Dept.</b>  |   |
| 13a. STATE<br><b>Maryland</b>  |  |  |  | 13b. CITY OR TOWN<br><b>Baltimore</b>   |  | 13c. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                            |   |
| 14. FATHER'S NAME<br>FIRST <b>Orville</b> MIDDLE <b>E.</b> LAST <b>Brower</b>  |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>Ruth</b> MIDDLE <b>Weiss</b> LAST  |  |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><b>No</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>453-32-3822</b>   |  | 17. INFORMANT<br><b>Edward R. Traynor</b>   |  | ADDRESS<br><b>Same as #13.</b>   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br><b>4151</b><br>IMMEDIATE CAUSE (a) <b>CARDIO RESPIRATORY ARREST</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>UNKNOWN - POSSIBLE PULMONARY EMBOLISM</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>EMBOLISM</b>  |  |  |  |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>55 MIN -</b> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |  |  |   |  |  |   |
| 19a. DATE OF OPERATION<br><b>1/20/82</b>   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>DISCLOSING INJURY @ HAND</b>  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>1/27</b> , 19 <b>82</b> , to <b>2/12</b> , 19 <b>82</b> , that (I) (we) lost<br>saw the deceased alive on <b>2/12</b> , 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |  |  |  |   |  |  |   |
| 22b. SIGNATURE<br><b>[Signature]</b>   |  |  |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>        |  | 22c. DATE SIGNED<br><b>2/12/82</b>   |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>RONALD J. KENDIG</b>   |  |  |  | 22e. ADDRESS<br><b>UNION MEMORIAL HOSP. BALTO, MD.</b>  |  |  |   |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>Feb. 17, 1982</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Woodlawn Cemetery</b>  |  | 23d. LOCATION<br>CITY OR TOWN <b>Woodlawn</b> COUNTY <b>Baltimore</b> STATE <b>Maryland</b>                                |   |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Ruck Towson Funeral Home, Inc. Towson, Md. 21204</b>  |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>FEB 16 1982</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>   |   |

12255

SECRET



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 4 2 6 8

|   |  |  |   |  |  |
|---|--|--|---|--|--|
| 1. FOR STATE REGISTRAR  |  | 2. DATE OF DEATH   |   | 2b. HOUR   |  |
| 1. DECEASED NAME<br>(THREE OR PRINTS)   |  | 2. DATE OF DEATH   |   | 2b. HOUR   |  |
| HENRY, D. F. TROW   |  | 2-27-82  |   | 2:55 AM  |  |
| 3. SEX  | 4. RACE  | 5. DATE OF BIRTH   | 6. AGE (IN YEARS LAST BIRTHDAY)                                     | IF UNDER 1 YEAR  |  |
| MALE  | WHITE  | 04 23 1896   | 85 YRS.   | MONTHS DAYS HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   | 7b. CITIZEN OF WHAT COUNTRY?   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |  |  |
| MARYLAND  | U.S.A.   |  | BALTIMORE CITY MD.  |  |  |
| 10. CITY OR TOWN OF DEATH   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  | 12b. KIND OF BUSINESS OR INDUSTRY                                   |  |  |
| BALTIMORE   | ST. AGNES HOSPITAL   | PIPEFITTER   | EXXON   |  |  |
| 13a. STATE  |  | 13b. COUNTY  | 13c. CITY OR TOWN   | 13d. INSIDE CITY LIMITS?   | 13e. STREET ADDRESS                          |
| MARYLAND  | ---  | BALTIMORE  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 1209 CLEVELAND STREET, 21230                 |
| 14. FATHER'S NAME   |  | 15. MOTHER'S MAIDEN NAME   |   | 16. ADDRESS  |  |
| FREDERICK TROW  |  | KATE UNKNOWN   |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)   |  | 16b. SOCIAL SECURITY NO.   |   | 17. INFORMANT  |  |
| NO  |  | 214-01-4419  |   | JUNE B. TROW 1209 CLEVELAND STREET, 21230                                      |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4439 Sepsis   |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| DUE TO, OR AS A CONSEQUENCE OF (b) gangrenous feet  |  |  |   |  |  |
| DUE TO, OR AS A CONSEQUENCE OF (c) peripheral vascular disease  |  |  |   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)  |  |  |   |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   | 20a. AUTOPSY?  |  |
|   |  |  |   | YES <input type="checkbox"/> NO <input type="checkbox"/>                       |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |
|   |  | P.M. 19  |   |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM, ETC.)  |   | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                 |  |
|   |  |  |   |  |  |
| 22a. I certify that (a) (this hospital) attended the deceased from 2/26/82 to 2/27/82, that (b) (we) saw the deceased alive on 2/27/82, and that in my (our) opinion death occurred on the date and hour and from the causes stated above (c) (we) did (did not) view the body after death. |  |  |   |  |  |
| 22b. SIGNATURE  |  | DEGREE   |   | 22c. DATE SIGNED   |  |
| Jerry D. Skarbek M.D.   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>               |   | 2/27/82  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  | 22e. ADDRESS   |   |  |  |
| Jerry D. Skarbek  |  | 900 CATONER AVE BALTIMORE MD   |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |  | 23b. DATE  |   | 23c. NAME OF CEMETERY OR CREMATORY   |  |
| BURIAL  |  | 03-02-82   |   | WESTERN CEMETERY   |  |
| 24. FUNERAL DIRECTOR NAME   |  | 25a. DATE REC'D. BY REGISTRAR  |   | 25b. REGISTRAR'S SIGNATURE   |  |
| HUBBARD FUNERAL HOME, INC.  |  | MAR 1 1982   |   | James J. Nathan  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon-copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  | REG. NO. 8 2 0 4 2 6 9   |  |   |  |
|--|--|--|--|--|--|---|--|
| 1. DECEASED NAME FIRST MIDDLE LAST<br><b>AMBER CHRISTINE TROXEL</b>  |  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>2 24 82</b>   |  |   |  |
| 1. SEX<br><b>Female</b>  |  | 4. RACE<br><b>white</b>  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>2 21 82</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS HOURS MIN.<br><b>- YRS. 2 15 09</b>   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MARYLAND</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City MD</b>  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Univ. of Md. Hosp</b> |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>N/A</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>-</b>   |  |
| 13a. STATE<br><b>Maryland</b>  |  |  |  | 13b. COUNTY<br><b>A.A.</b>   |  | 13c. CITY OR TOWN<br><b>GLEN BURNIE</b>   |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>JAMES E. TROXEL</b>  |  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>AMY CHRISTINA CLAY</b>  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>N/A</b>  |  |  |  | 16b. SOCIAL SECURITY NO.<br><b>NONE</b>  |  | 17. INFORMANT ADDRESS<br><b>GEORGE E. FOSS, III 2204 BELLEVIEW RD. 21228</b>  |  |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br><b>7599 IMMEDIATE CAUSE (a) Cardiopulmonary Arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>ventricular arrhythmias</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>congenital abnormalities</b>   |  |  |  |  |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>-</b>  |  |  |  |  |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)  |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>2/22</b> , 19 <b>82</b> to <b>2/24</b> , 19 <b>82</b> , that (I) (we) lost saw the deceased alive on <b>2/24</b> , 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |   |  |
| 22b. SIGNATURE<br><b>Suzanne M. Laskas, M.D.</b>   |  |  |  | DEGREE<br><b>M.D.</b>  |  | 22c. DATE SIGNED<br><b>2/24/82</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>SUZANNE M Laskas, M.D.</b>   |  |  |  | 22e. ADDRESS<br><b>UNIVERSITY OF MARYLAND HOSPITAL</b>   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>BURIAL</b>   |  | 23b. DATE<br><b>02-27-82</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>LOUDON PARK</b>   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>BALTIMORE CITY MARYLAND</b>   |  |
| 24. FUNERAL DIRECTOR NAME<br><b>HUBBARD FUNERAL HOME, INC.</b>   |  |  |  | ADDRESS<br><b>4107 WILKENS AVE. 21229</b>  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>FEB 26 1982</b>   |  |
|  |  |  |  | 25b. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>   |  |   |  |

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 4 2 7 0

1. FOR  
STATE  
REGISTRAR

REG. NO.

|   |  |   |   |   |   |
|---|--|---|---|---|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>LARRY TRUITT</b>                               |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>2 / 1 / 82</b>  |   | 2b. HOUR<br>10 <sup>24</sup> <sub>P</sub> M   |   |
| 3. SEX<br><b>MALE</b>   | 4. RACE<br><b>WHITE</b>  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>1 9 82</b>   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>24 days</b> RS.   |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>SALISBURY Md</b>  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.</b>  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTO. CITY</b> MD.                                  |   |
| 10. CITY OR TOWN OF DEATH<br><b>BALTO.</b>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>MERCY HOSPITAL</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>INFANT</b> |   | 12b. KIND OF BUSINESS OR INDUSTRY           |
| 13a. STATE<br><b>Md</b>   |  | 13b. COUNTY<br><b>U.S.</b>  | 13c. CITY OR TOWN<br><b>BALTO</b>   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS<br><b>601 BAKER ST.</b> |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>LAWRENCE TRUITT</b>  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>NO INFORMATION</b>  |   |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>NO</b> |  | 16b. SOCIAL SECURITY NO.<br><b>NONE</b>   |   | 17. INFORMANT<br>ADDRESS  |   |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

5100

DUE TO, OR AS A CONSEQUENCE OF

(b)

Conditions, if any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, NOT RELATED TO IMMEDIATE CAUSE OF DEATH OR PART I

*cardiovascular arrest*  
*Bacterial sepsis*  
*pneumonia, possible bronchopulmonary fistula*  
*decreased fluid intake, pulmonary*  
*interstitial emphysema*

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

MEDICAL CERTIFICATION

|   |  |  |  |  |   |
|---|--|--|--|--|---|
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>      | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 10             |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 19, PART 1 OR PART 2) |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |   |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last<br>saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |   |
| 22b. SIGNATURE<br><i>Marinela K. Macaraj</i>  |  | DEGREE   |  | 22c. DATE SIGNED<br><b>2/2/82</b>  |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>MARINELA MACARAJ</b>  |  | 22e. ADDRESS<br><b>301 ST. PAUL PLACE, BALTO. Md.</b>                  |  |  |   |

|  |                             |   |  |
|--|-----------------------------|---|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Removal</b> | 23b. DATE<br><b>2/10/82</b> | 23c. NAME OF CEMETERY OR CREMATORY                      | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Anatomy Board</b>           |                             | ADDRESS<br><b>Balto., Md.</b>                           |  |
| 25a. DATE REC'D. BY REGISTRAR                                  |                             | 25b. REGISTRAR'S SIGNATURE<br><i>Frances Jan Nathan</i> |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



*[Faint, mostly illegible handwritten text on lined paper. Some words like 'TWO' and 'FIVE' are visible.]*

ANALYSIS OF THE  
RESULTS OF THE  
EXPERIMENT  
CONDUCTED AT  
THE  
UNIVERSITY OF  
MICHIGAN  
IN THE  
YEAR 1900  
BY  
J. H. HARRIS  
AND  
J. H. HARRIS



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |   |  | 8 2 0 4 2 7 1   |  |  |  |  |  |  |  |   |  |
|---|--|---|--|---|--|--|--|--|--|--|--|---|--|
| 1. FOR<br>STATE<br>REGISTRAR  |  |   |  | CERTIFICATE OF DEATH  |  |  |  |  |  |  |  |   |  |
| I. DECEASED NAME<br>(TYPE OR PRINT)   |  |   |  | 2a. DATE OF DEATH   |  |  |  | 2b. HOUR   |  |  |  |   |  |
| FLORENCE HARDESTY TUCKER  |  |   |  | 2/28/82   |  |  |  | 12:55p   |  |  |  |   |  |
| 3 SEX   |  | 4 RACE  |  | 5. DATE OF BIRTH  |  | 6. AGE (IN YEARS LAST BIRTHDAY)                                  |  | IF UNDER 1 YEAR  |  | IF UNDER 24 HRS.   |  |   |  |
| Female  |  | White   |  | Oct. 2, 1924  |  | 57   |  | MONTHS DAYS  |  | HOURS MIN.   |  |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  | 7b. CITIZEN OF WHAT COUNTRY?  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                             |  |  |  |  |  |   |  |
| Baltimore, Md.  |  | U. S. A.  |  |   |  | Baltimore City, MD.  |  |  |  |  |  |   |  |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE) |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |  |  |   |  |
| Baltimore   |  | St. Agnes Hospital  |  |   |  | Payroll Clerk  |  | Paint Mnfg.  |  |  |  |   |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |   |  | 13b. INSIDE CITY LIMITS?  |  |  |  | 13c. STREET ADDRESS  |  |  |  |   |  |
| Md. Baltimore Catonsville   |  |   |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |  |  | 6007 Black Friars Circle   |  |  |  |   |  |
| 14. FATHER'S NAME   |  |   |  | 15. MOTHER'S MAIDEN NAME  |  |  |  |  |  |  |  |   |  |
| Joseph S. Hardesty  |  |   |  | Mary A. Rheinholt   |  |  |  |  |  |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)  |  |   |  | 16b. SOCIAL SECURITY NO.  |  | 17. INFORMANT'S ADDRESS  |  |  |  |  |  |   |  |
| No  |  |   |  | 219-10-0481   |  | Catonsville, Md. 21228.  |  |  |  |  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardiorespiratory arrest</u><br>4360 } DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Cerebrovasc. accident and septicemia</u><br>(c) <u>Extensive Liver Cirrhosis</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |   |  |   |  |  |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>24 days |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><u>Alcoholic liver Cirrhosis</u>   |  |   |  |   |  |  |  |  |  |  |  |   |  |
| 19a. DATE OF OPERATION  |  |   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  |  | 20a. AUTOPSY?  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |  |   |  |
| 2-19-82   |  |   |  | Intractable ascites, Hepato-renal   |  |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | YES <input type="checkbox"/> NO <input type="checkbox"/>       |  |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART I OR PART 2) |  |  |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  |  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>2-2-</u> 19 <u>82</u> to <u>2-28-</u> 19 <u>82</u> - that (I) (we) last saw the deceased alive on <u>2-28-</u> 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |   |  |   |  |  |  |  |  |  |  |   |  |
| 22b. SIGNATURE  |  |   |  | DEGREE  |  |  |  | 22c. DATE SIGNED   |  |  |  |   |  |
| Merchant Deepak   |  |   |  |   |  |  |  | 2-28-82 1:00p  |  |  |  |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  |   |  | 22e. ADDRESS  |  |  |  |  |  |  |  |   |  |
| Merchant D.P.   |  |   |  | 3350 Wilkum Ave - Balto - MD 21229.   |  |  |  |  |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |  |   |  | 23b. DATE   |  | 23c. NAME OF CEMETERY OR CREMATORY                               |  | 23d. LOCATION  |  |  |  |   |  |
| Burial  |  |   |  | Mar. 3, 1982  |  | Linganore Cemetery   |  | Unionville, Maryland   |  |  |  |   |  |
| 24. FUNERAL DIRECTOR'S NAME   |  |   |  | 25a. DATE REC'D. BY REGISTRAR   |  |  |  | 25b. REGISTRAR'S SIGNATURE   |  |  |  |   |  |
| Sterling Funeral Estate<br>736 Edmondson Ave.<br>Catonsville, Md. 21228   |  |   |  | MAR 3 1982  |  |  |  | [Signature]  |  |  |  |   |  |





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then pages 3 and 4 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  | REG. NO. 8 2 0 4 2 7 2  |  |   |  |
|--|--|---|--|---|--|---|--|
| 1. FOR STATE REGISTRAR   |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR 2b. HOUR   |  |   |  |
| 1. DECEASED NAME FIRST MIDDLE LAST<br>MCKINLEY TURNER  |  |   |  | FEBRUARY 19, 1982 2:45 AM   |  |   |  |
| 3. SEX Male  |  | 4. RACE Black   |  | 5. DATE OF BIRTH MONTH DAY YEAR 20 16   |  | 6. AGE (IN YEARS LAST BIRTHDAY) 65  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) VA   |  | 7b. CITIZEN OF WHAT COUNTRY? USA  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH  |  |
| 10. CITY OR TOWN OF DEATH Baltimore  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) JOHNS HOPKINS HOSPITAL |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)   |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| 13a. STATE MD  |  | 13b. COUNTY   |  | 13c. CITY OR TOWN Baltimore   |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST Spencer Turner   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Thompson  |  | 13e. STREET ADDRESS 1600 W. Mt. Royal Avenue  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No   |  | 16b. SOCIAL SECURITY NO. 218-01-3974  |  | 17. INFORMANT ADDRESS Catherine Turner 1600 W. Mt. Royal  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) 1539 CARDIAC ARREST<br>DUE TO, OR AS A CONSEQUENCE OF (b) DISSEMINATED COLON CARCINOMA<br>DUE TO, OR AS A CONSEQUENCE OF (c)   |  |   |  |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) NONE  |  |   |  |   |  |   |  |
| 19a. DATE OF OPERATION NONE  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |   |  |
| 22a. I certify that (1) (this hospital) attended the deceased from 2/16, 1982, to 2/19, 1982, that (1) (we) last saw the deceased alive on 2/19, 1982, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (1) (we) did (did not) view the body after death. |  |   |  |   |  |   |  |
| 22b. SIGNATURE Gerald McManma  |  |   |  | DEGREE MD   |  | 22c. DATE SIGNED 2/19/82  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) LERARD MCMANMA   |  |   |  | 22e. ADDRESS JOHNS HOPKINS HOSPITAL DEPT SURGERY  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial   |  | 23b. DATE 2/24/82   |  | 23c. NAME OF CEMETERY OR CREMATORY Eastview Mem. Pk.  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Co. MD  |  |
| 24. FUNERAL DIRECTOR NAME Wm. C. March F/H 1101 E. North Ave.  |  |   |  | 25a. DATE REC'D. BY REGISTRAR FEB 24 1982   |  | 25b. REGISTRAR'S SIGNATURE  |  |

1401 BP

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RECEIVED  
JAN 11 1964



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JAN 11 1964

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JAN 11 1964

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JAN 11 1964

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 4 2 7 3

REG. NO.

|  |   |   |   |  |  |
|--|---|---|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Walter C. TURNER SR.</b>   |   |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>February 12, 1982</b>                                 |  | 2b. HOUR<br><b>5:50<sup>a</sup></b>  |
| 3. SEX<br><b>M ALE</b>   | 4. RACE<br><b>BLACK</b>   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>11 24 04</b>   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>77</b> YRS.                                    |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>VIRGINIA</b>   | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.                    |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Maryland General Hospital</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)                                |  | 12b. KIND OF BUSINESS OR INDUSTRY  |
| 13a. STATE<br><b>MD.</b>   |   | 13b. COUNTY<br><b>BALTIMORE</b>   | 13c. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS<br><b>416 POPLAR GROVE ST.</b>                                   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>WALTER TURNER</b>   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>ELLA BROWN</b>  |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>YES</b>  |   | 16b. SOCIAL SECURITY NO.<br><b>098-01-0169</b>  |   | 17. INFORMANT ADDRESS<br><b>AGNES F. TURNER 416 POPLAR GROVE ST.</b>                 |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <b>Cardiopulmonary arrest</b><br><b>4100</b> DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Myocardial infarction</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)  |   |   |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |   |   |   |  |  |
| 19a. DATE OF OPERATION   |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)       |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>February 10, 19 82</b> , to <b>February 12, 19 82</b> , that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on <b>February 12, 19 82</b> , and that in <input checked="" type="checkbox"/> (my) (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) (do not) view the body after death. |   |   |   |  |  |
| 22b. SIGNATURE<br><b>Joseph Ganey MD</b>   |   | DEGREE<br><b>MD.</b>  |   | 22c. DATE SIGNED<br><b>2/12/82</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>GANEY Joseph Ganey, M.D.</b>   |   | 22e. ADDRESS<br><b>c/o Maryland General Hospital</b>  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>BURIAL</b>   | 23b. DATE<br><b>2/17/82</b>   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>MD. VETERANS CEMETERY</b>  |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>CHELTENHAM MD</b>                   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>WM. C. MARCH F/H 1101 E. NORTH AVE</b>  |   | 25. DATE REC'D. BY REGISTRAR<br><b>FEB 16 1982</b><br>REGISTRAR'S SIGNATURE<br><b>Ann. J. [Signature]</b>   |   |  |  |

MEDICAL CERTIFICATION

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, this certificate should be detached for use as the burial-transit permit. Then please remove carbonpapers, Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

18 JAN 1952

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

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(VRA 15, 4)

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |                          |   |  |   |  |                                   |   |
|---|--|---|--------------------------|---|--|---|--|-----------------------------------|---|
| 1. FOR STATE REGISTRAR  |  |   |                          |   |  |   |  |                                   |   |
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  |   | 2. DATE OF DEATH         |   |  | 2b. HOUR  |  |                                   |   |
| John J. Tueliz  |  |   | 2/12/82                  |   |  | 114 <sup>PM</sup>   |  |                                   |   |
| 3. SEX  |  | 4. RACE   |                          | 5. DATE OF BIRTH  |  | 6. AGE (IN YEARS LAST BIRTHDAY)                                     |  | 7. IF UNDER 1 YEAR                |   |
| Male  |  | Cauc.   |                          | 5 20 17   |  | 64 YRS.   |  | MONTHS DAYS HOURS MIN.            |   |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY?  |                          | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |  |                                   |   |
| New York  |  | USA   |                          |   |  | CITY MD.  |  |                                   |   |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |                          |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)    |  | 12b. KIND OF BUSINESS OR INDUSTRY |   |
| BALT  |  | UMD MEMS  |                          |   |  | Employee  |  | Dept of Agric                     |   |
| 13a. STATE  |  | 13b. COUNTY   |                          | 13c. CITY OR TOWN   |  | 13d. INSIDE CITY LIMITS?  |  | 13e. STREET ADDRESS               |   |
| MD  |  | Montgomery  |                          | Rockville   |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 1509 Gerard Str                   |   |
| 14. FATHER'S NAME   |  |   | 15. MOTHER'S MAIDEN NAME |   |  |   |  |                                   |   |
| John Tueliz   |  |   | Rosanna                  |   |  |   |  |                                   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)  |  |   | 16b. SOCIAL SECURITY NO. |   | 17. INFORMANT ADDRESS                                    |   |  |                                   |   |
| Yes, WWII   |  |   | 096-03-7078              |   | John A. Tueliz, 1509 Gerard St                           |   |  |                                   |   |
| 18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:  |  |   |                          |   |  |   |  |                                   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |
| IMMEDIATE CAUSE (a) <u>cardiopulmonary arrest</u>   |  |   |                          |   |  |   |  |                                   |   |
| DUE TO, OR AS A CONSEQUENCE OF  |  |   |                          |   |  |   |  |                                   |   |
| b) <u>cervical spine injury</u>   |  |   |                          |   |  |   |  |                                   |   |
| DUE TO, OR AS A CONSEQUENCE OF  |  |   |                          |   |  |   |  |                                   |   |
| c) <u>fall</u>  |  |   |                          |   |  |   |  |                                   |   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>8809</u>  |  |   |                          |   |  |   |  |                                   |   |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |                          |   | 20a. AUTOPSY?  |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |                                   |   |
|   |  |   |                          |   | YES <input type="checkbox"/> NO <input type="checkbox"/> |   | YES <input type="checkbox"/> NO <input type="checkbox"/>       |                                   |   |
| 21a. ACCIDENT WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 1 12 1982   |                          | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)  |  |   |  |                                   |   |
|   |  |   |                          | fell down stairs  |  |   |  |                                   |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input checked="" type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |                          | 21f. LOCATION   |  | CITY OR TOWN  |  | COUNTY STATE                      |   |
|   |  | home  |                          | STREET  |  |   |  |                                   |   |
| 22a. I certify that (I) (this hospital) attended the deceased from 1/12/82 to 2/12/82, that (I) (we) last saw the deceased alive on 2/12/82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |                          |   |  |   |  |                                   |   |
| 22b. SIGNATURE  |  |   | DEGREE                   |   |  | 22c. DATE SIGNED  |  |                                   |   |
| Mark Caroz  |  |   |                          |   |  | 2/12/82   |  |                                   |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  |   | 22e. ADDRESS             |   |  |   |  |                                   |   |
| MARK CAROZ  |  |   | UMD HOSPITAL             |   |  |   |  |                                   |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)  |  | 23b. DATE   |                          | 23c. NAME OF CEMETERY OR CREMATORY  |  | 23d. LOCATION   |  |                                   |   |
| Burial  |  | Feb. 16 82  |                          | Arlington National  |  | Arlington, Virginia   |  |                                   |   |
| 24. FUNERAL DIRECTOR<br>NAME  |  |   | ADDRESS                  |   |  | 25a. DATE REC'D. BY REGISTRAR                                       |  | 25b. REGISTRAR'S SIGNATURE        |   |
| Pearson's Funeral Home, Falls Church, Va.   |  |   |                          |   |  | FEB 18 1982   |  | [Signature]                       |   |

MEDICAL CERTIFICATION

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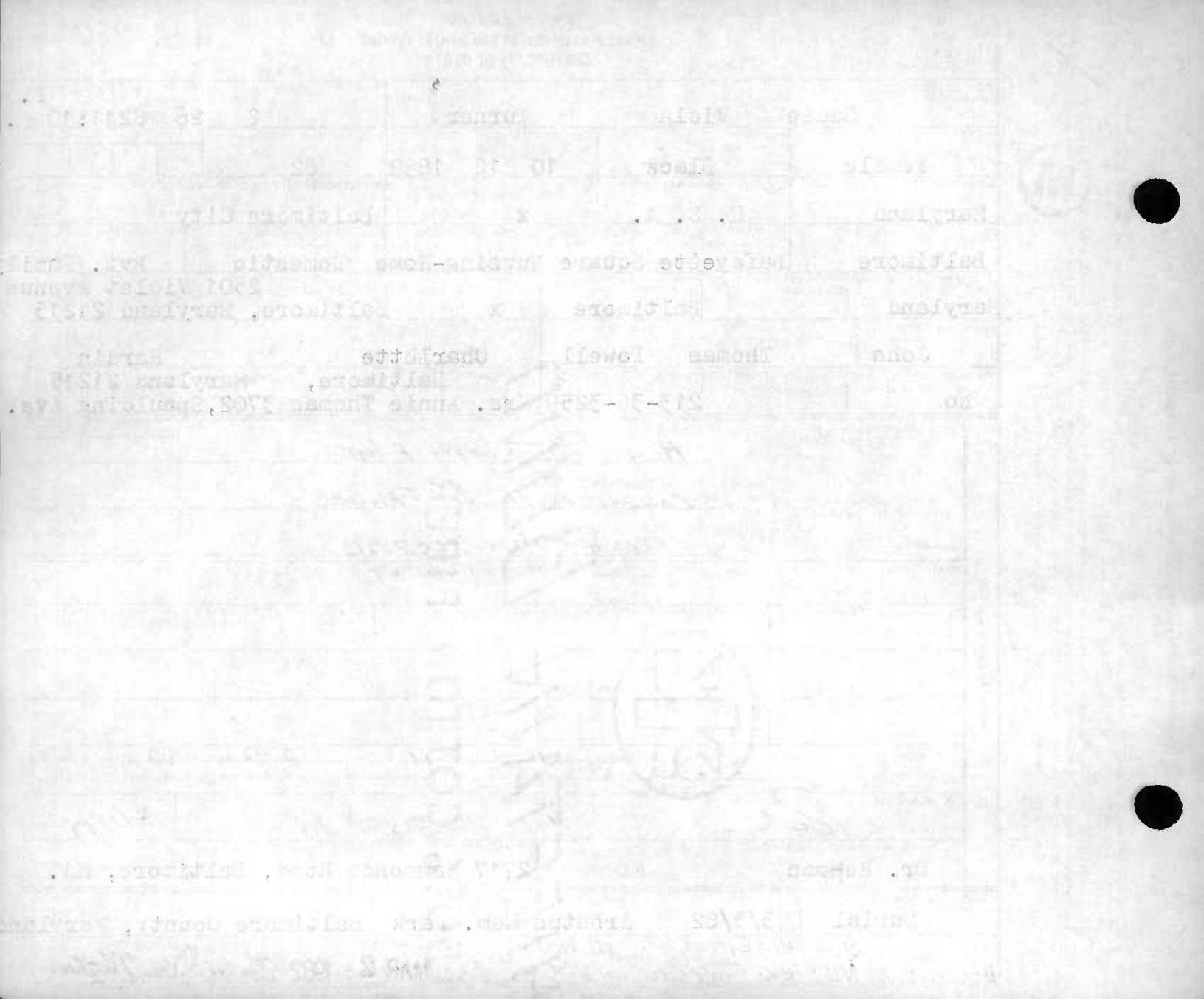


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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |   |   |   |  |  |  |
|--|--|--|--|---|---|---|--|--|--|
| 1. FOR STATE REGISTRAR   |  | REG. NO. 82 04275  |  |   |   |   |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br>Sadie Viola Turner  |  |  |  |   | 2a. DATE OF DEATH MONTH DAY YEAR<br>2 26 82 |   |  | 2b. HOUR P.<br>11:10 M.  |  |
| 3. SEX<br>Female   |  | 4. RACE<br>Black   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>10 12 1899  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>82 YRS.  |  | IF UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 24 HRS. HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U. S. A.   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.                                      |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Lafayette Square Nursing-Home |  |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Domestic                    |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Pvt. Famil.   |  |
| 13a. STATE<br>Maryland   |  | 13b. COUNTY  |  | 13c. CITY OR TOWN<br>Baltimore  |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>John Thomas Powell   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Charlotte Hardin  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>No  |   |   |  |  |  |
|  |  | 16b. SOCIAL SECURITY NO.<br>213-36-3259  |  | 17. INFORMANT Baltimore, Maryland 21215<br>Mrs. Annie Thomas 3702 Spaulding Ave.  |   |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>ACUTE PULMONARY EDEMA</u><br>4140<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>CONGESTIVE HEART FAILURE</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>CORONARY ATHEROSCLEROSIS</u><br>CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |  |  |   |   |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |  |  |   |   |   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |   |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>11--</u> , 19 <u>81</u> , to <u>2-26-</u> 19 <u>82</u> , that (I) (we) last saw the deceased alive on <u>2-26-</u> 19 <u>81</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |  |  |   |   |   |  |  |  |
| 22b. SIGNATURE<br><i>Rehman</i>  |  | DEGREE<br>MD   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                  |   |   |  | 22c. DATE SIGNED<br>3/1/82   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Dr. Rehman  |  | MD   |  | 22e. ADDRESS<br>2717 Hammonds Road, Baltimore, Md.  |   |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial   |  | 23b. DATE<br>3/3/82  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Arbutus Mem. Park   |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore County, Maryland                        |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Herbert E. NUTTER  |  | BALTIMORE, MARYLAND<br>ADDRESS<br>3035 W. NORTH  |  | 25a. DATE REC'D. BY REGISTRAR<br>MAR 2 1982   |   | 25b. REGISTRAR'S SIGNATURE<br>Frances Van Nuth  |  |  |  |



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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrars, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers, Pages 1 and 2 should be filed in the office after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |   |  |  |  |   |   |                      | REG. NO. 82 04276                           |  |
|---|--|--|---|--|--|--|---|---|----------------------|---|--|
| 1. FOR STATE REGISTRAR  |  |  | 1. DECEASED NAME (TYPE OR PRINT) <b>NELLIE LENORE TYERYAR</b> |  |  |  | 2a. DATE OF DEATH MONTH <b>2</b> DAY <b>16</b> YEAR <b>82</b> |   | 2b. HOUR <b>7P</b> M |   |  |
| 3. SEX <b>Female</b>  |  | 4. RACE <b>White</b>   |   | 5. DATE OF BIRTH MONTH <b>1</b> DAY <b>08</b> YEAR <b>94</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY) <b>88</b> YRS.   |   | IF UNDER 1 YEAR MONTHS <b></b> DAYS <b></b>   |                      | IF UNDER 24 HRS. HOURS <b></b> MIN. <b></b> |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>   |  | 7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>   |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b> MD.                               |   |   |                      |   |  |
| 10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>ST. AGNES HOSPITAL</b> |   |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>NURSE</b>                   |   | 12b. KIND OF BUSINESS OR INDUSTRY <b>PRIVATE DUTY</b>   |                      |   |  |
| 13a. STATE <b>MARYLAND</b>  |  | 13b. COUNTY <b>BALTIMORE</b>   |   | 13c. CITY OR TOWN <b>ARBUTUS</b>   |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 13e. STREET ADDRESS <b>966 REGINA DRIVE, 21227</b>  |                      |   |  |
| 14. FATHER'S NAME FIRST <b>EDWARD</b> MIDDLE <b></b> LAST <b>SWOMLEY</b>  |  |  |   | 15. MOTHER'S MAIDEN NAME FIRST <b>IDA</b> MIDDLE <b></b> LAST <b>LEASE</b>   |  |  |   |   |                      |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>   |  | 16b. SOCIAL SECURITY NO. <b>214-18-7450</b>  |   | 17. INFORMANT <b>DESMA USHER</b>   |  | ADDRESS <b>966 REGINA DRIVE, 21227</b>   |   |   |                      |   |  |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br><b>4442</b> IMMEDIATE CAUSE (a) <b>CHE, renal failure.</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>spas - leg ulcers.</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:<br>DUE TO, OR AS A CONSEQUENCE OF (c) <b></b><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b></b> |  |  |   |  |  |  |   |   |                      |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>Diabetes mellitus</b>   |  |  |   |  |  |  |   |   |                      |   |  |
| 19a. DATE OF OPERATION <b>1/27/82</b>   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>(D) femoral ant occlusion</b>  |   |  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |                      |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. <b></b> MONTH <b></b> DAY <b>19</b> YEAR <b></b>   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |   |   |                      |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) <b></b>  |   | 21f. LOCATION STREET <b></b> CITY OR TOWN <b></b> COUNTY <b></b> STATE <b></b>   |  |  |   |   |                      |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>1/10/82</b> to <b>2/16/82</b> that (we) last saw the deceased alive on <b>2/16/82</b> and that in our opinion death occurred on the date and hour and from the causes stated above.   |  |  |   |  |  |  |   |   |                      |   |  |
| 22b. SIGNATURE <b>Sema Khan</b>   |  |  |   | DEGREE <b></b>   |  |  |   | 22c. DATE SIGNED <b>2/16/82</b>   |                      |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Sema Khan</b>  |  |  |   | 22e. ADDRESS <b>ST. AGNES HOSPITAL, 900 S. CATON AVENUE</b>  |  |  |   |   |                      |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>   |  | 23b. DATE <b>02-19-82</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY <b>MOUNT OLIVET</b>   |  | 23d. LOCATION CITY OR TOWN <b>FREDERICK</b> COUNTY <b>FREDERICK</b> STATE <b>MD.</b>         |   |   |                      |   |  |
| 24. FUNERAL DIRECTOR NAME <b>HUBBARD FUNERAL HOME, INC. 4107 WILKENS AVE.</b> ADDRESS <b>21229</b>  |  |  |   | 25a. DATE REC'D. BY REGISTRAR <b>FEB 19 1982</b>   |  | 25b. REGISTRAR'S SIGNATURE <b>James Van Nuthan</b>   |   |   |                      |   |  |



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| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |  |  |   |  |  |  | 8 2 0 4 2 7 7  |     |            |  |
|--|--|--|--|--|--|---|--|--|--|--|-----|------------|--|
| 1. FOR STATE REGISTRAR   |  | REG. NO.   |  |  |  |   |  |  |  |  |     |            |  |
| 1. DECEASED NAME (TYPE OR PRINT)   |  | FIRST  |  | MIDDLE   |  | LAST  |  | 2a. DATE OF DEATH  |  | MONTH  | DAY | YEAR       | 2b. HOUR                                     |
| RUTH   |  | A.   |  | (TYLOR)  |  | (TYLER)   |  | 2  |  | 1  | 82  | 9:05 PM    |  |
| 3. SEX   |  | 4. RACE  |  | 5. DATE OF BIRTH   |  | 6. AGE (IN YEARS LAST BIRTHDAY)                                     |  | IF UNDER 1 YEAR  |  | IF UNDER 24 HRS  |     |            |  |
| F  |  | B  |  | 1 25 93  |  | 89  |  | MONTHS   |  | DAYS   |     | HOURS MIN. |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |  |  |  |  |     |            |  |
| MD   |  | USA  |  |  |  | BALTIMORE CITY MD   |  |  |  |  |     |            |  |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |  |  |   |  |  |  |  |     |            |  |
| BALTIMORE  |  | LUTHERAN   |  |  |  |   |  |  |  |  |     |            |  |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |  |  |   |  |  |  |  |     |            |  |
|  |  |  |  |  |  |   |  |  |  |  |     |            |  |
| 13a. STATE   |  | 13b. COUNTY  |  | 13c. CITY OR TOWN  |  | 13d. INSIDE CITY LIMITS?  |  | 13e. STREET ADDRESS  |  |  |     |            |  |
| MARYLAND   |  |  |  | BALTIMORE  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 140 W. LAFAYETTE AVE.  |  |  |     |            |  |
| 14. FATHER'S NAME  |  |  |  | 15. MOTHER'S MAIDEN NAME   |  |   |  |  |  |  |     |            |  |
| FIRST MIDDLE LAST  |  |  |  | FIRST MIDDLE LAST  |  |   |  |  |  |  |     |            |  |
|  |  |  |  | Anna   |  |   |  | Woods  |  |  |     |            |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)  |  |  |  | 16b. SOCIAL SECURITY NO.   |  |   |  | 17. INFORMANT ADDRESS  |  |  |     |            |  |
| No   |  |  |  | 218-10-1669  |  |   |  | Jerome Dangerfield 2409 E. Chase St.   |  |  |     |            |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |  |  |  |  |  |   |  |  |  |  |     |            | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART I. DEATH WAS CAUSED BY:   |  |  |  |  |  |   |  |  |  |  |     |            |  |
| IMMEDIATE CAUSE (a) <del>CARD</del> CARDIOPULMONARY ARREST   |  |  |  |  |  |   |  |  |  |  |     |            |  |
| 4860 DUE TO, OR AS A CONSEQUENCE OF  |  |  |  |  |  |   |  |  |  |  |     |            |  |
| (b) SEPSIS   |  |  |  |  |  |   |  |  |  |  |     |            |  |
| DUE TO, OR AS A CONSEQUENCE OF   |  |  |  |  |  |   |  |  |  |  |     |            |  |
| (c) PNEUMONIA  |  |  |  |  |  |   |  |  |  |  |     |            |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)   |  |  |  |  |  |   |  |  |  |  |     |            |  |
| 19a. DATE OF OPERATION   |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |  | 20a. AUTOPSY?  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |     |            |  |
|  |  |  |  |  |  |   |  | YES <input type="checkbox"/> NO <input type="checkbox"/>                       |  | YES <input type="checkbox"/> NO <input type="checkbox"/>       |     |            |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  |  | 21b. TIME OF INJURY  |  |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) |  |  |     |            |  |
|  |  |  |  | HOUR A.M. MONTH DAY YEAR   |  |   |  |  |  |  |     |            |  |
|  |  |  |  | P.M. 19  |  |   |  |  |  |  |     |            |  |
| 21d. INJURY OCCURRED   |  |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  |   |  | 21f. LOCATION  |  |  |     |            |  |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |  |  |  |  |   |  | STREET CITY OR TOWN COUNTY STATE   |  |  |     |            |  |
| 22a. I certify that (I) (this hospital) attended the deceased from JAN 15, 19 82, to FEB 1, 19 82, that (I) (we) lost saw the deceased alive on FEB 1, 19 82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |   |  |  |  |  |     |            |  |
| 22b. SIGNATURE   |  |  |  |  |  |   |  | DEGREE   |  | 22c. DATE SIGNED   |     |            |  |
| JOHN H. WEBER MD   |  |  |  |  |  |   |  |  |  |  |     |            |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  |  |  |  |  |   |  | 22e. ADDRESS   |  |  |     |            |  |
| JOHN H. WEBER MD   |  |  |  |  |  |   |  | LUTHERAN HOSPITAL  |  |  |     |            |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  |  |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY                                  |  |  |  | 23d. LOCATION  |     |            |  |
| Burial   |  |  |  | 2/6/82   |  | Pleasant Rest Cem.  |  |  |  | Towson   |     |            |  |
|  |  |  |  |  |  |   |  |  |  | CITY OR TOWN COUNTY STATE MD                                   |     |            |  |
| 24. FUNERAL DIRECTOR   |  |  |  |  |  |   |  | 25a. DATE REC'D. BY REGISTRAR  |  | 25b. REGISTRAR'S SIGNATURE                                     |     |            |  |
| NAME ADDRESS   |  |  |  |  |  |   |  | FEB 4 1982   |  | Name Jan [Signature]   |     |            |  |
| Wm. C. March F/H, Inc. 1101 E. North Ave.  |  |  |  |  |  |   |  |  |  |  |     |            |  |





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It is to be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 4 2 7 8

REG. NO.

|   |  |   |  |  |  |
|---|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>Walter E. Underwood   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>February 10, 1982                             |  | 2b. HOUR<br>3:35a M  |
| 3. SEX<br>Male  | 4. RACE<br>White   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>May 7, 1891   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>90<br>YRS.  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.                                      |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN)<br>Balto. Md.   | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.                           |  |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Maryland General Hospital |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Retired Salesman | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13a. STATE<br>Md.   | 13b. CITY OR TOWN<br>Balto.  | 13c. INSIDE CITY LIMITS<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   | 13e. STREET ADDRESS<br>11736 Greenspring Ave.  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>William Underwood   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Margaret Eichner   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>215-22-7543  | 17. INFORMANT ADDRESS<br>Mrs. Erma U. Stallard Lutherville, Md.                      |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Arteriosclerotic Cardiovascular Disease<br>4292<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br>Renal Failure, Diabetes Mellitus  |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>      | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |
| 22a. I certify that (X) (this hospital) attended the deceased from January 3, 1982, to February 10, 1982, that (X) (we) last saw the deceased alive on February 10, 1982, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (we) (did) (did not) view the body after death.  |  |   |  |  |  |
| 22b. SIGNATURE<br>Eric Fisher   |  | DEGREE<br>MD  |  | DATE SIGNED<br>2/10/82   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Eric Fisher, M.D.  |  | 22e. ADDRESS<br>C/O Maryland General Hospital   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial  | 23b. DATE<br>Feb. 12, 82   | 23c. NAME OF CEMETERY OR CREMATORY<br>Loudon Park Cemetery  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore, Md.                   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Eline Funeral Home  |  | ADDRESS<br>Reisterstown, Md. 21136  |  | 25a. DATE REC'D. BY REGISTRAR<br>FEB 16 1982                                   |  |
|   |  | 25b. REGISTRAR'S SIGNATURE<br>[Signature]   |  |  |  |

MEDICAL CERTIFICATION

9-9

BP 5





4

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be contacted at once.

| FOR<br>1. STATE<br>REGISTRAR   |  |  |  | STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  | 8 2 0 4 2 7 9<br>REG. NO.  |  |  |  |
|--|--|--|--|---|--|---|--|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>ISAAC   |  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>FEBRUARY 19, 1982  |  |   |  | 2b. HOUR<br>7 P.M.   |  |  |  |
| 3. SEX<br>MALE   |  | 4. RACE<br>WHITE   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>MAR. 28, 1922   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>59 YRS.  |  | IF UNDER 1 YEAR<br>MONTHS DAYS   |  | IF UNDER 24 HRS.<br>HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MARYLAND  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.                                      |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>3939 CLARKS LANE APT. C (21215) |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>OWNER                       |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>CABS  |  |  |  |
| 13a. STATE<br>MARYLAND   |  | 13b. COUNTY  |  | 13c. CITY OR TOWN<br>BALTIMORE  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br>3939 CLARKS LANE APT. C (21215)                               |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>DAVID UNGER  |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>BERTHA SILVERMAN   |  |   |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>YES WWII NAVY  |  |  |  | 16b. SOCIAL SECURITY NO.<br>220-05-7225   |  | 17. INFORMANT<br>ADDRESS<br>MRS. YETTA ALBOM 2400 SMITH AVE. #21209                             |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) 4100 Cardiac arrest<br>DUE TO, OR AS A CONSEQUENCE OF (b) Acute myocardial infarct<br>DUE TO, OR AS A CONSEQUENCE OF (c) ASCVD general<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>acute<br>acute<br>4-5 yrs |  |  |  |   |  |   |  |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c)<br>Chronic bronch syndrome, chronic peptic disease   |  |  |  |   |  |   |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 19c. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 19d. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  |  | 20b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 20c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2)                  |  |  |  |  |  |
| 21a. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  |  |  | 21b. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21c. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |  |  |
| 22a. I certify that (a) (this hospital) attended the deceased from 9-13, 1980, to 2-19, 1982, that (b) (we) lost<br>saw the deceased alive on 10/16, 1981, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (1) (we) (did) (did not) view the body after death.                               |  |  |  |   |  |   |  |  |  |  |  |
| 22b. SIGNATURE<br>H. Gerald Oster  |  |  |  | 22c. DATE SIGNED<br>2/20/82   |  |   |  |  |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>H. GERALD OSTER   |  |  |  | 22e. ADDRESS<br>3635 OLD COURT RD. (21208)  |  |   |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>BURIAL  |  |  |  | 23b. DATE<br>2/21/82  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>ARLINGTON   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>BALTIMORE, MD.                         |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME SOL LEVINSON & BROS.<br>6010 REISTERSTOWN RD. BALTIMORE, MD. (21215)  |  |  |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br>FEB 24 1982  |  | 25b. REGISTRAR'S SIGNATURE<br>Ramon J. Natch   |  |  |  |

978



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copiers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

BP 4

DHMH-16 50M 1/B1  
(VRA 15, 4)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 4 2 8 0

|   |  |  |  |
|---|--|--|--|
| 1. FOR<br>STATE<br>REGISTRAR  |  | REG. NO.   |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Harry E. Upton JR.   |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>February 27, 1982  |  |
| 3. SEX<br>MALE  |  | 2b. HOUR<br>8:00 P.M.  |  |
| 4. RACE<br>CAUCASIAN  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>65 YRS.   |  |
| 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>06 12 16  |  | IF UNDER 1 YEAR<br>MONTHS DAYS   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MARYLAND   |  | IF UNDER 24 HRS.<br>HOURS MIN.   |  |
| 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.   |  |
| 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>SUPERVISOR   |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>CONT. CAN   |  |
| 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Maryland General Hospital  |  |  |  |
| 13a. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 13b. STREET ADDRESS<br>125 RAVENSWOOD CT.  |  |
| 13c. CITY OR TOWN<br>JOPPA  |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>HARRY E. UPTON SR.  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>HAZEL BYUS  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>YES   |  | 16b. SOCIAL SECURITY NO.<br>213017819  |  |
| 16c. IF YES, GIVE WAR OR DATES<br>WW II   |  | 17. INFORMANT<br>ADDRESS<br>LILLIAN UPTON 125 RAVENSWOOD CT.   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u><br><u>4413</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost<br>(b) <u>Septic Shock</u><br>(c) <u>Infection of Abdominal Aortic Graft</u>                          |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><u>Acute Renal failure. Acute Respiratory failure.</u>   |  |  |  |
| 19a. DATE OF OPERATION<br><u>February 27, 1982</u>  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><u>Infected Abdominal Aortic Graft</u>                                 |  |
| 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART I OR PART 2)  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  |
| 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a. I certify that (x) (this hospital) attended the deceased from <u>January 21</u> , 19 <u>82</u> , to <u>February 27</u> , 19 <u>82</u> , that (we) lost saw the deceased alive on <u>February 27</u> , 19 <u>82</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above (we) (did) (did not) view the body after death. |  |  |  |
| 22b. SIGNATURE<br><u>Prasad</u>   |  | 22c. DATE SIGNED<br><u>2-28-82</u>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>PRASAD, M.</u>  |  | 22e. ADDRESS<br><u>c/o Maryland General Hospital</u>   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><u>CREMATION</u>  |  | 23b. DATE<br><u>3/1/82</u>   |  |
| 23c. NAME OF CEMETERY OR CREMATORY<br><u>WESTVIEW</u>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><u>BALTO. BALTO. MD.</u>   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><u>Jeff Cook</u>  |  | 25a. DATE REC'D. BY REGISTRAR<br><u>MAR 1 1982</u>   |  |
| ADDRESS<br><u>1211 Chesapeake Ave.</u>  |  | 25b. REGISTRAR'S SIGNATURE<br><u>Francis J. Nathan</u>   |  |

MEDICAL CERTIFICATION



NAME: CAUCASIAN  
DATE: 11-10-62  
FOLIO: 614  
HOSPITAL: GENERAL HOSPITAL  
SUPERVISOR: GOVT. EMP.  
HARRY: 102 HAVENWOOD CT.  
WILLIAM: 102 HAVENWOOD CT.  
ADDRESS: 102 HAVENWOOD CT.

SECTION: 102 HAVENWOOD CT.  
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or reinterment. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 4 2 8 1

REG. NO.

|   |  |   |  |  |   |
|---|--|---|--|--|---|
| 1. FOR STATE REGISTRAR  |  | 2a. DATE OF DEATH   |  | 2b. HOUR   |   |
| DECEASED NAME (TYPE OR PRINT) <b>Joseph W. Vaisnoris</b>  |  | MONTH DAY YEAR <b>February 14 1982</b>  |  | 9:25 <sup>M</sup>  |   |
| 3. SEX: <b>Male</b>   | 4. RACE: <b>White</b>  | 5. DATE OF BIRTH  |  | 6. AGE (IN YEARS LAST BIRTHDAY)  |   |
|   |  | MONTH DAY YEAR <b>Dec 1 1911</b>  |  | 70 YRS.  |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Mass.</b>  | 7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.                               |   |
| 10. CITY OR TOWN OF DEATH <b>Baltimore</b>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Mercy Hospital</b> |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Policeman</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY <b>UMBC</b> |
| 13a. STATE <b>Md.</b>   |  | 13b. COUNTY <b>-</b>  | 13c. CITY OR TOWN <b>Balto.</b>  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   |
| 14. FATHER'S NAME   |  | 15. MOTHER'S MAIDEN NAME  |  |  |   |
| FIRST MIDDLE LAST <b>Vincent Vaisnoris</b>  |  | FIRST MIDDLE LAST <b>Petronella Vilkauskas</b>  |  |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>yes</b>  |  | 16b. SOCIAL SECURITY NO. <b>WW11 013-03-5633</b>  |  | 17. INFORMANT ADDRESS <b>same</b>  |   |
|   |  |   |  | <b>Margaret Vaisnoris (wife) address</b>   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>pulmonary embolus</b><br>2500 DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: <b>CHF, peripheral vascular disease</b><br>(b) <b>CHF, peripheral vascular disease</b><br>DUE TO, OR AS A CONSEQUENCE OF <b>DM.</b><br>(c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b> |  |   |  |  |   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>None</b>  |  |   |  |  |   |
| 19a. DATE OF OPERATION <b>None</b>  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |   |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |   |  |  |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)               |   |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>2/7 1/21 19 82</b> to <b>2/14 19 82</b> , that (I) (we) last saw the deceased alive on <b>2/14 19 82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |   |  |  |   |
| 22b. SIGNATURE <b>[Signature]</b>   |  | DEGREE  |  | 22c. DATE SIGNED <b>2/14/82</b>  |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>[Signature]</b>  |  | 22e. ADDRESS <b>Mercy Hosp</b>  |  |  |   |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>   |  | 23b. DATE <b>2/19/82</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY <b>St. Michael's</b>                                      |   |
| 23d. LOCATION CITY OR TOWN <b>Boston</b>  |  | 23e. STATE <b>Mass.</b>   |  |  |   |
| 24. FUNERAL DIRECTOR <b>Schlimuenk Funeral Home, Inc.</b>   |  | 25a. DATE REC'D. BY REGISTRAR <b>FEB 16 1982</b>  |  | 25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>  |   |
| 3331 Brehms Lane, Balto. Md. 21213  |  |   |  |  |   |





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

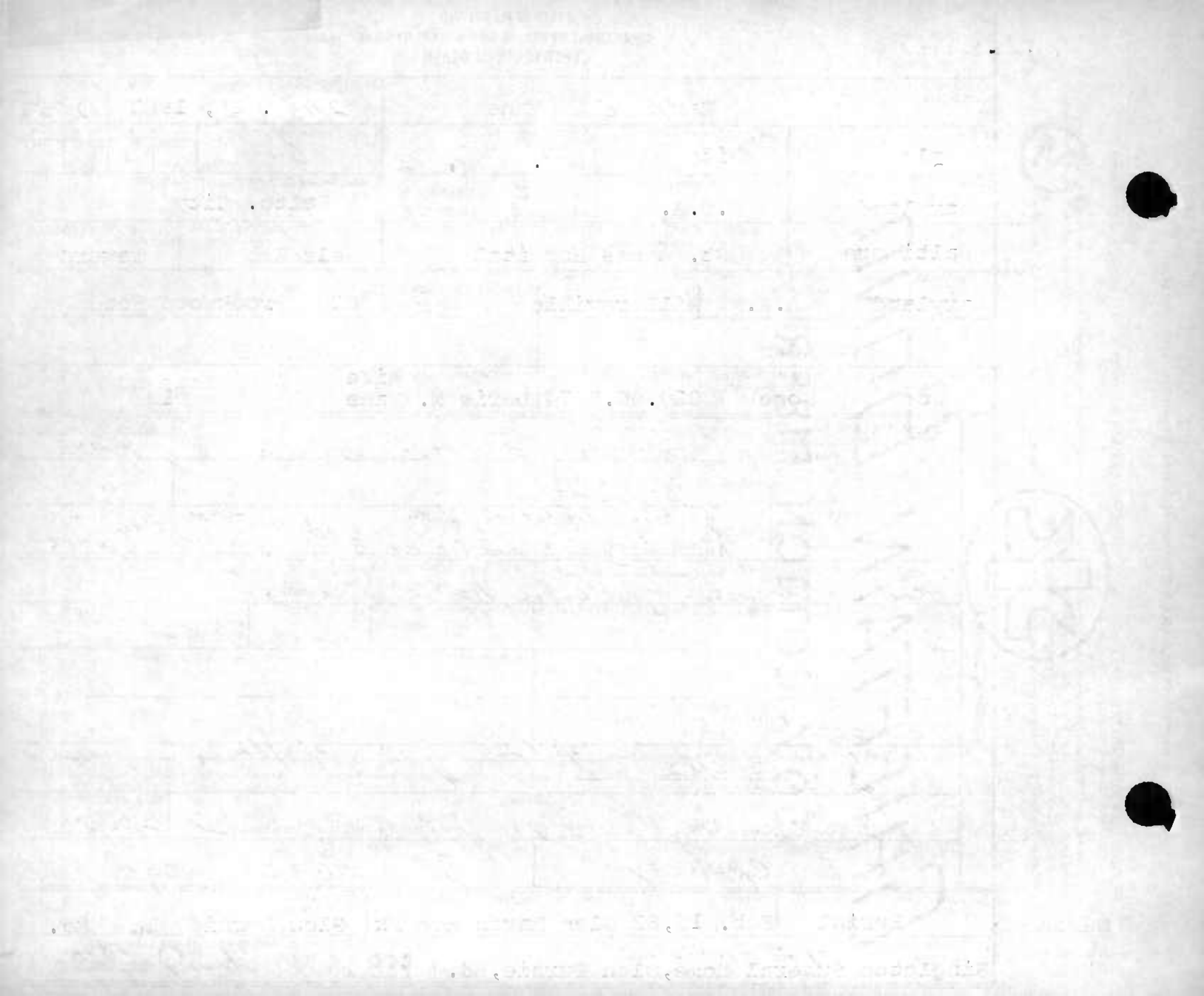
8 2 0 4 2 8 2

1- FOR  
STATE  
REGISTRAR

REG. NO.

|   |  |   |  |   |   |  |   |  |  |
|---|--|---|--|---|---|--|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>James Harrison Vane  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>Feb. 12, 1982 |   |   | 2b. HOUR<br>12 35 P.M.   |   |  |  |
| 3. SEX<br>Male  |  | 4. RACE<br>White  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>Nov. 18, 1912   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>69 YRS.                       |   |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Balto. City MD.          |   |  |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>St. Agnes Hospital |  |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Self Emb                    |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Tavern   |  |  |
| 13a. STATE<br>Maryland  |  |   | 13b. CITY OR TOWN<br>A.A. Millersville               |   | 13c. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |   | 13d. STREET ADDRESS<br>8299 Brookwood Road |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>UNKNOWN   |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>UNKNOWN  |   |  |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>None   |  | 17. INFORMANT<br>Wife<br>Doris M. Vane  |   | ADDRESS<br>Same as 13  |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Extensive Bronchopneumonia</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>ASPIRATION</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br><u>gastric dilatation, with vomiting in association &amp; dehydration &amp; cachexia</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>DAYS</u><br>"<br><u>days to weeks</u> |  |   |  |   |   |  |   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)<br><u>Hepatic cirrhosis; Calcific Aortic Stenosis</u>  |  |   |  |   |   |  |   |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED<br>(ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |   |  |   |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |  |   |  |  |
| 22a. I certify that (this hospital) attended the deceased from <u>2/3/82</u> , 19____, to <u>2/12/82</u> , 19____, that (we) last saw the deceased alive on <u>2/12/82</u> , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (do not) view the body after death.  |  |   |  |   |   |  |   |  |  |
| 22b. SIGNATURE<br><u>R. E. CRANLEY</u>  |  |   |  | DEGREE<br>MD  |   | 22c. DATE SIGNED<br>2/12/82                                      |   |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>R. E. CRANLEY  |  |   |  | 22e. ADDRESS<br>ST AGNES HOSP.  |   |  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial  |  | 23b. DATE<br>Feb. 15, 82  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Glen Haven Mem Pk   |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Glen Burnie AA Md. |   |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Singleton Funeral Home, Glen Burnie, Md.  |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br>FEB 16 1982  |   |  |   |  |  |
|   |  |   |  | 25b. REGISTRAR'S SIGNATURE<br><u>Thom J. Gault</u>  |   |  |   |  |  |

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Item 17 film G565/ 3-17-82 jdr

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE

FOR  
STATE  
REGISTRAR

CERTIFICATE OF DEATH

REG. NO.

|  |  |   |   |   |  |
|--|--|---|---|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>HOWARD F VAN HORN</b>   |  |   | 2a. DATE OF DEATH<br>MONTH <b>02</b> DAY <b>05</b> YEAR <b>82</b>                   |   | 2b. HOUR<br><b>9:40 P</b>  |
| 3. SEX<br><b>M</b>   | 4. RACE<br><b>Caucasian</b>  | 5. DATE OF BIRTH<br>MONTH <b>02</b> DAY <b>23</b> YEAR <b>10</b>  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>71</b> YRS.   | IF UNDER 1 YEAR<br>MONTHS <b></b> DAYS <b></b>   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MD</b>   | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.</b>  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>CITY</b> MD.   |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTO</b>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>UNIVERSITY</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Engineer</b> | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Electrical</b>  |  |
| 13a. STATE<br><b>MD</b>  | 13b. CITY OR TOWN<br><b>FROSTBURG</b>  | 13c. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   | 13d. STREET ADDRESS<br><b>97 HILL ST 21532</b>                                      |   |  |
| 14. FATHER'S NAME<br>FIRST <b>RAY</b> MIDDLE <b>F</b> LAST <b>VANHORN</b>  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>NAOMI</b> MIDDLE <b></b> LAST <b>STALLINGS</b>   |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>No</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>214-07-5328</b>  |   | 17. Informant <b>MILDRED D.</b> ADDRESS<br><b>Margaret Van Horn Frostburg, Md.</b>                    |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CRANIOPNEUMOTIC RESPIRATORY ARREST</b><br><b>3940</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>MITRAL VALVE REPLACEMENT</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF (c) <b></b> |  |   |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>3 1/2 hrs</b><br><b>1 1/2 wks</b>                                       |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)  |  |   |   |   |  |
| 19a. DATE OF OPERATION<br><b>1-22-82</b>   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>mitral stenosis</b>  |   | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)      |   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                   |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>1-20</b> , 19 <b>82</b> , to <b>2-5</b> , 19 <b>82</b> , that (I) (we) saw the deceased alive on <b>2-5</b> , 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |   |   |   |  |
| 22b. SIGNATURE<br><b>Sergio Tavares, M.D.</b>  |  | DEGREE<br><b></b>   |   | 22c. DATE SIGNED<br><b>2-5-82</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>SERGIO TAVARES</b>   |  | 22e. ADDRESS<br><b>University Hospital</b>  |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Removal</b>  | 23b. DATE<br><b>2/10/82</b>  | 23c. NAME OF CEMETERY OR CREMATORY  |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Anatomy Board</b>   |  | ADDRESS<br><b>Balto., Md.</b>   |   | 25a. DATE REC'D. BY REGISTRAR <b>FEB 17 1982</b> 25b. REGISTRAR'S SIGNATURE<br><b>James J. Nathan</b> |  |

|  |  |                                   |  |
|--|--|-----------------------------------|--|
| 1. Name of the person or organization<br>2. Address<br>3. City<br>4. State<br>5. Zip |  | 6. Date<br>7. Time                |  |
| 8. Subject<br>9. Remarks   |  | 10. Signature<br>11. Printed Name |  |

10



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

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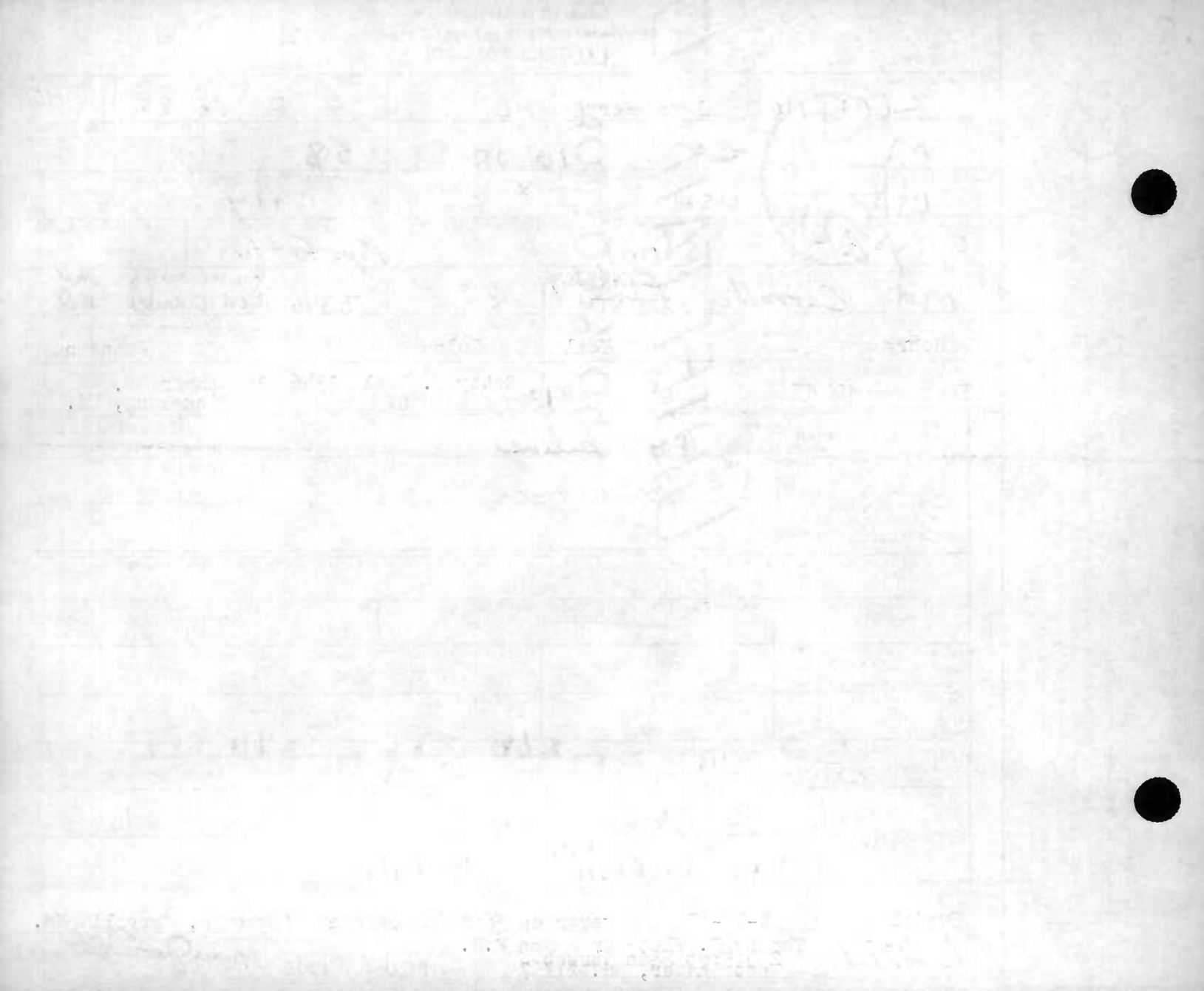
Item # G 565 3/8/82 GAB

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

B 2 0 4 2 8 4

REG. NO.

|   |  |  |   |  |  |   |  |  |
|---|--|--|---|--|--|---|--|--|
| 1. FOR<br>STATE<br>REGISTRAR  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>2 18 82                         |  |  | 2b. HOUR<br>8:45 AM   |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br>CLARENCE Alexa nder VEAL   |  |  | 3. SEX<br>M   |  |  | 4. RACE<br>White  |  |  |
| 5. DATE OF BIRTH MONTH DAY YEAR<br>10 28 23   |  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>58 YRS                           |  |  | 7. IF UNDER 1 YEAR MONTHS DAYS<br>3   |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>USA  |  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA                                 |  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  |
| 9. BALTIMORE CITY OR COUNTY OF DEATH<br>CITY MD.  |  |  | 10. CITY OR TOWN OF DEATH<br>CITY-Balt.                             |  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>SINAI   |  |  |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Pipefitter   |  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>-                              |  |  | 13a. STREET ADDRESS<br>Pinksburg Rd.<br>3346 Old Gamber Rd.   |  |  |
| 13a. STATE<br>Md  |  |  | 13b. CITY OR TOWN<br>Pinksburg                                      |  |  | 13c. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>Henry - Veal   |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Lula - Johnson        |  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES NO OR UNKNOWN)<br>Yes   |  |  |
| 16b. SOCIAL SECURITY NO.<br>263-24-4218   |  |  | 17. INFORMANT<br>Betty G. Veal<br>C. HART                           |  |  | 17. ADDRESS<br>3346 Old Gamber Rd.<br>Pinksburg, Md.  |  |  |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) Resp failure<br>4860<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) pneumonia<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)  |  |  |   |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:0  |  |  |   |  |  |   |  |  |
| 19a. DATE OF OPERATION  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                    |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |  |  |
| 21d. INJURY OCCURRED<br>WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT HOME <input type="checkbox"/>  |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 2/18, 1982, to 2/18, 1982, that (I) (well) last saw the deceased alive on 2/18, 1982, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |   |  |  |   |  |  |
| 22b. SIGNATURE<br>John E Gordon MD  |  |  |   |  |  | 22c. DATE SIGNED<br>2/18/82   |  | 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>JOHN E GORDON MD  |
| 22e. ADDRESS<br>SINAI   |  |  |   |  |  | 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial   |  |  |
| 23b. DATE<br>2-20-82  |  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Evergreen Memorial Gardens    |  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>Pinksburg, Carroll Md.   |  |  |
| 24. FUNERAL DIRECTOR<br>Thomas D. Fletcher & Son F.H.<br>254 First Main Street<br>Westminster, Md. 21157  |  |  |   |  |  | 25a. DATE REC'D. BY REGISTRAR<br>FEB 22 1982  |  |  |





TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITH PAGES 3, 4, AND 5, AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH   |  |                      |   |   |  |   |   |   |  | REG. NO. 2 0 4 2 8 5  |  |
|---|--|----------------------|---|---|--|---|---|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Percy E. Veanie</b>  |  |                      |   |   |  | 2a. DATE KNOWN OF DEATH<br>ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR <b>2 21 1982</b>  |   | 2b. HOUR <b>M</b>   |  |   |  |
| 3. SEX <b>Male</b>  |  | 4. RACE <b>Black</b> |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR <b>6 30 32</b>                             |  | 6. AGE (IN YEARS<br>LAST BIRTHDAY) <b>49 YRS.</b>   |   | 7c. DATE PRONOUNCED DEAD<br>MONTH DAY YEAR <b>2 21 1982</b>           |  | 7d. HOUR <b>10:59 a M</b>   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>VA</b>   |  |                      | 7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>   |   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City,</b> MD. |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   |  |                      | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>748 N. Dennison Street</b> |   |  |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) |   |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| 13a. STATE <b>MD</b>  |  | 13b. COUNTY          |   | 13c. CITY OR TOWN<br><b>Baltimore</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |   | 13e. STREET ADDRESS<br><b>748 N. Denison St.</b>                      |  |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Thomas Veanie</b>  |  |                      |   |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Alice Crumbley</b>  |   |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN) <b>No</b>   |  |                      |   | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>216-30-7918</b> |  | 17. INFORMANT ADDRESS<br><b>Alice C. Veanie 748 N. Denison St.</b>  |   |   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Arteriosclerotic cardiovascular disease</b><br><b>4292</b><br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.<br>(b) _____<br>(c) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>DUE TO, OR AS A CONSEQUENCE OF  |  |                      |   |   |  |   |   |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).   |  |                      |   |   |  |   |   |   |  |   |  |
| 19a. DATE OF OPERATION  |  |                      |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                             |  |   |   |   |  | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  |                      |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                    |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |   |   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  |                      |   | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)                   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |   |  |   |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . |  |                      |   |   |  |   |   |   |  |   |  |
| ACTUAL SIGNATURE <b>Virginia L. Dolan</b>   |  |                      |   | TITLE (SPECIFY)<br><b>Assistant</b> M.D. MEDICAL EXAMINER                     |  |   |   | DATE SIGNED <b>2/22/82</b>  |  |   |  |
| EXAMINER'S NAME (TYPE OR PRINT)<br><b>Virginia L. Dolan, M.D.</b>   |  |                      |   | ADDRESS<br><b>111 Penn St. Balto., MD.</b>                                    |  |   |   |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |  |                      | 23b. DATE<br><b>2/25/82</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>King Memorial Pk.</b> |   |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Co. MD</b> |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Wm. C. March F/H 1101 E. North Ave.</b>  |  |                      |   |   |  | 25a. DATE REC'D BY REGISTRAR<br><b>FEB 23 1982</b>  |   | 25b. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>                      |  |   |  |





Vertical text on the left side, possibly a date or reference number, including characters like 19, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100.

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Small text in the bottom right section.

Large text at the bottom left, possibly a signature or title.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of one.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  |   |   |  |                                      |   |   |  |  |
|---|--|---|--|---|---|--|--------------------------------------|---|---|--|--|
| 1. FOR STATE REGISTRAR  |  |   |  |   |   |  |                                      |   |   |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  |   |  |   | 2a. DATE OF DEATH                                       |  |                                      |   |   | 2b. HOUR   |  |
| LAWSON  |  |   |  |   | VESSELLS  |  |                                      |   |   | M  |  |
| 3. SEX  |  | 4. RACE   |  | 5. DATE OF BIRTH  |   | 6. AGE (IN YEARS LAST BIRTHDAY)  |                                      | IF UNDER 1 YEAR   |   | IF UNDER 24 HRS  |  |
| MALE  |  | BLACK   |  | MONTH DAY YEAR<br>8 30 13   |   | 68 YRS   |                                      | MONTHS DAYS   |   | HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  | 7b. CITIZEN OF WHAT COUNTRY?  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH   |                                      |   |   |  |  |
| MARYLAND  |  | US  |  |   |   | CITY MD.   |                                      |   |   |  |  |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)   |                                      | 12b. KIND OF BUSINESS OR INDUSTRY                                   |   |  |  |
| BALTIMORE   |  | 1910 N. FULTON AVE.   |  |   |   | MUSICIAN   |                                      |   |   |  |  |
| 13a. STATE  |  |   |  |   | 13b. COUNTY   |  | 13c. CITY OR TOWN                    |   | 13d. INSIDE CITY LIMITS?  |  |  |
| MARYLAND  |  |   |  |   |   |  | BALTIMORE                            |   | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 14. FATHER'S NAME   |  |   |  |   | 15. MOTHER'S MAIDEN NAME                                |  |                                      |   |   |  |  |
| JOSEPH LAWSON   |  |   |  |   | FINETTA A. HARRIS                                       |  |                                      |   |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)  |  |   |  |   | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES) |  | 17. INFORMANT ADDRESS                |   |   |  |  |
| YES   |  |   |  |   | 195-05-4648   |  | ARDELLE VESSELLS 1910 N. FULTON AVE. |   |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) _____<br>DUE TO, OR AS A CONSEQUENCE OF (b) <u>Hepatocellular Carcinoma</u><br>DUE TO, OR AS A CONSEQUENCE OF (c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last                    |  |   |  |   |   |  |                                      |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____   |  |   |  |   |   |  |                                      |   |   |  |  |
| 19a. DATE OF OPERATION  |  |   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   |  |                                      | 20a. AUTOPSY?   |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |  |
|   |  |   |  |   |   |  |                                      | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | YES <input type="checkbox"/> NO <input type="checkbox"/>       |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |                                      |   |   |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |                                      |   |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>January</u> 19 <u>82</u> , to <u>February</u> 19 <u>82</u> , that (I) (we) lost<br>saw the deceased alive on <u>17 Feb</u> 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |  |   |  |   |   |  |                                      |   |   |  |  |
| 22b. SIGNATURE<br><u>Allen G. Meek MD</u>   |  |   |  |   |   | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |                                      |   | 22c. DATE SIGNED<br>2-25-82   |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Allen G. Meek MD   |  |   |  |   |   | 22e. ADDRESS<br>Johns Hopkins Oncology Center  |                                      |   |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>BURIAL   |  |   |  | 23b. DATE<br>2-26-82  |   | 23c. NAME OF CEMETERY OR CREMATORY<br>MARYLAND NAT. MEM. PK.   |                                      | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>LAUREL MARYLAND       |   |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>E.L. PHILLIPS 1721 N. MONROE ST.  |  |   |  |   |   | 25a. DATE REC'D. BY REGISTRAR<br>FEB 25 1982   |                                      |   |   |  |  |

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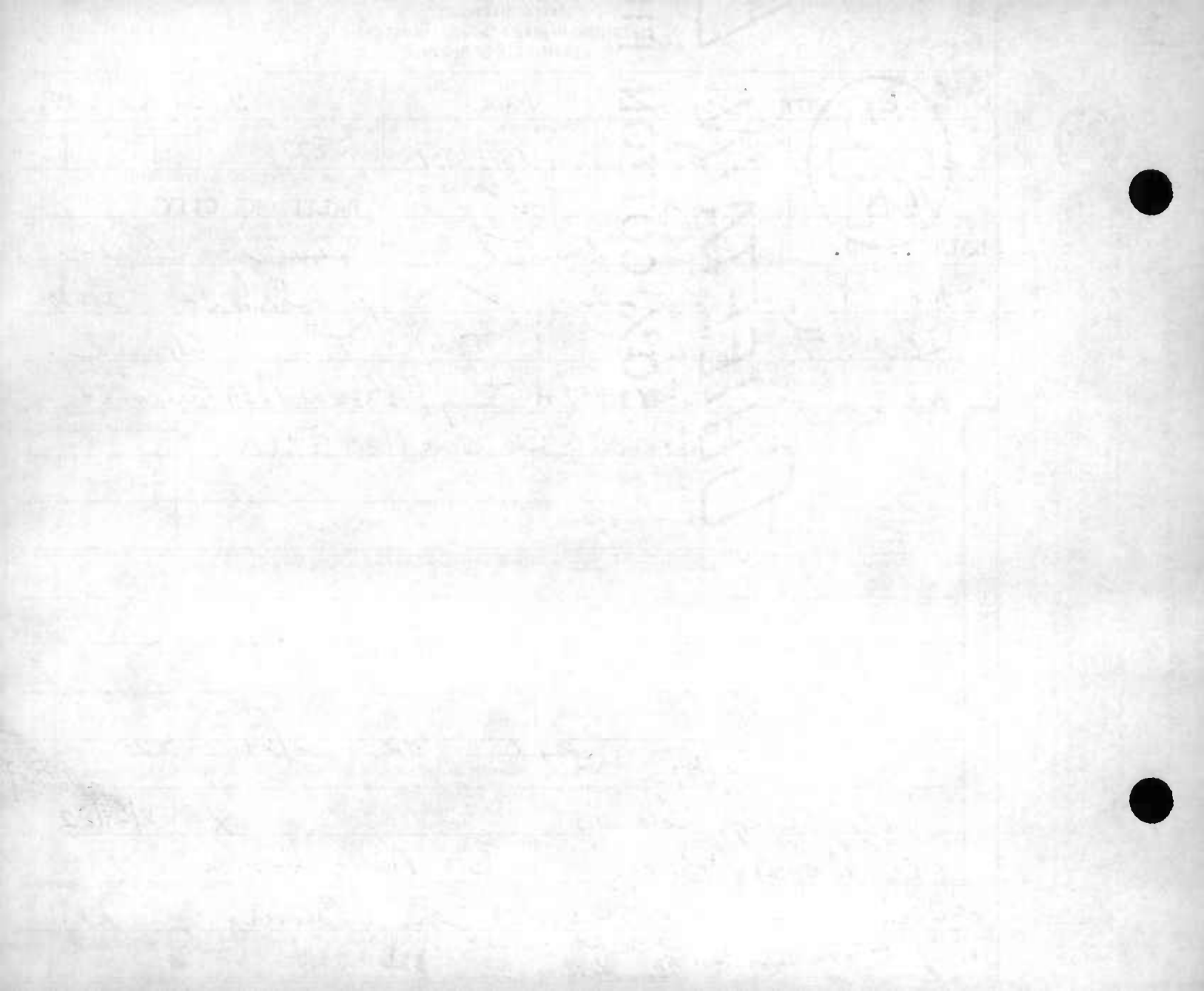
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Part 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified by phone.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  | 8 2 0 4 2 8 7  |  |   |  |
|---|--|--|--|--|--|---|--|
| 1 - FOR STATE REGISTRAR   |  |  |  | REG. NO.   |  |   |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>ELIZETTA JOHANNA VICK</b>  |  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR 2 24 82 2b. HOUR 3:45 AM  |  |   |  |
| 3. SEX <b>Female</b>  |  | 4. RACE <b>White</b>   |  | 5. DATE OF BIRTH MONTH DAY YEAR 4-12-1901  |  | 6. AGE (IN YEARS LAST BIRTHDAY) 80 YRS  |  |
| 7a. BIRTH PLACE (STATE OR FOREIGN COUNTRY) <b>Ind.</b>  |  | 7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>                                   |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b> MD.  |  |
| 10. CITY OR TOWN OF DEATH <b>BALTO., MD.</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>St. Agnes Hospital</b> |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR AGES OF WORKING LIFE) <b>Saleslady</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY <b>Selling</b>  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) (13a. STATE) <b>Ind.</b> (13b. COUNTY) <b>Baltimore</b> (13c. CITY OR TOWN) <b>Baltimore</b>   |  |  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 13e. STREET ADDRESS <b>1120 Pence St.</b> 21230.  |  |
| 14. FATHER'S NAME (14a. FIRST) <b>John</b> (14b. MIDDLE) <b>F.</b> (14c. LAST) <b>Greist</b>  |  | 15. MOTHER'S MAIDEN NAME (15a. FIRST) <b>Tracy</b> (15b. MIDDLE) <b>C.</b> (15c. LAST) <b>Gronald</b>                            |  | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (16a. YES, NO OR UNKNOWN) <b>No</b> (16b. SOCIAL SECURITY NO. <b>215-09-4937 A</b> ) (16c. ADDRESS <b>Tracy &amp; Brown 1229 Carroll St.</b> ) |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br><b>4280 IMMEDIATE CAUSE (a) REFRACTORY CONGESTIVE HEART FAILURE</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last |  |  |  |  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <b>NO</b>  |  |  |  |  |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART I OR PART 2)   |  |   |  |
| 21d. INJURY OCCURRED WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>2/1</b> , 19 <b>82</b> , to <b>2/24</b> , 19 <b>82</b> , that (I) (we) lost saw the deceased alive on <b>2/24</b> , 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.               |  |  |  |  |  |   |  |
| 22b. SIGNATURE <b>W. Bradley Pifalo MD</b>  |  |  |  | DEGREE <b>MD</b>   |  | 22c. DATE SIGNED <b>2/24/82</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>W. BRADLEY PIFALO</b>  |  |  |  | 22e. ADDRESS <b>St. Agnes Hospital</b>   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>   |  | 23b. DATE <b>2-27-1982</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY <b>St. Olives Cem.</b>  |  | 23d. LOCATION (CITY OR TOWN) <b>Baltimore</b> COUNTY <b>Ind.</b> STATE  |  |
| 24. FUNERAL DIRECTOR (NAME) <b>John Brown, Inc.</b> ADDRESS <b>901 Indiana St.</b>  |  |  |  | 25a. DATE REC'D. BY REGISTRAR <b>FEB 4 5 1982</b> REGISTRAR'S SIGNATURE <b>[Signature]</b>   |  |   |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  | REG. NO. 8 2 0 4 2 8 8  |  |  |  |
|--|--|---|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Shannon N. Vill</b>   |  |   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR   |  | 2b. HOUR   |  |
| 3. SEX<br><b>Female</b>  |  | 4. RACE<br><b>Caucasian</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>07 27 81</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>YRS. MONTHS DAYS<br><b>7 10</b>   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City MD.</b>  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>University Hospital</b> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Infant</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>Maryland</b>  |  | 13b. COUNTY<br><b>Baltimore</b>   |  | 13c. CITY OR TOWN<br><b>Baltimore</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Gary M. Vill</b>  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Dinah E. Vill</b>   |  | 17. STREET ADDRESS<br><b>1575 Ingleside Ave</b>   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>None</b>   |  | 17. INFORMANT<br><b>Gary M. Vill</b>  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>heart failure</b><br><b>7455</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>open heart surgery</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Ventricular Septal Defect / Atrial Septal Defect</b>                                  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>Subacute Stenosis</b>  |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION<br><b>2/24/82</b>   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>Ventricular Septal Defect / Atrial Septal Defect</b>                             |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME STREET FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>2/20</b> , 19 <b>82</b> , to <b>2/27</b> , 19 <b>82</b> , that (I) (we) lost<br>saw the deceased alive on <b>2/27</b> , 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |  |   |  |   |  |  |  |
| 22b. SIGNATURE<br><b>Albert M. Lai, M.D.</b>   |  | DEGREE  |  | 22c. DATE SIGNED<br><b>2/27/82</b>  |  | 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Albert M. Lai, M.D.</b>  |  |
| 22e. ADDRESS<br><b>22 S. Greene Street</b>   |  |   |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>March 2, 1982</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Crestlawn</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Howard, Maryland</b>  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Harry H Witzke</b>  |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>MAR 2 1982</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Jean Nathan</b>   |  |



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified by item 18.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  |   |  |  |  |   |  |  |  |
|---|--|---|--|---|--|--|--|---|--|--|--|
| 1. FOR STATE REGISTRAR  |  | REG. NO.  |  | 8204289   |  |  |  |   |  |  |  |
| 1 DECEASED NAME (TYPE OR PRINT)   |  | FIRST   |  | MIDDLE  |  | LAST   |  | 2a. DATE OF DEATH MONTH DAY YEAR  |  | 2b. HOUR                                     |  |
| LILY  |  | M   |  |   |  | VITEK  |  | 2 / 16 / 82   |  | 1259 M                                       |  |
| 3 SEX   |  | 4 RACE  |  | 5 DATE OF BIRTH MONTH DAY YEAR  |  | 6 AGE (IN YEARS LAST BIRTHDAY)   |  | IF UNDER 1 YEAR MONTHS DAYS   |  | IF UNDER 24 HRS HOURS MIN                    |  |
| F   |  | W   |  | 9/21/03   |  | 78   |  |   |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  | 7b. CITIZEN OF WHAT COUNTRY?  |  | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH  |  |   |  |  |  |
| OHIO  |  | USA   |  |   |  | BALTO. CITY  |  |   |  | MD.  |  |
| 10 CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)   |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |   |  |  |  |
| BALTO   |  | BALTO. CITY HOSP  |  | H SWE   |  |  |  |   |  |  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  | 13b. STATE  |  | 13c. CITY OR TOWN   |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS   |  |  |  |
| MD.   |  | BALTO   |  | DUNDALK   |  |  |  | 3030 DUNGLOW RD   |  |  |  |
| 14 FATHER'S NAME FIRST MIDDLE LAST  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST  |  |   |  |  |  |   |  |  |  |
| ADOLPHUS  |  | EDWARDS   |  | LETTIE  |  | JOHNS  |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)   |  | 16b. SOCIAL SECURITY NO.  |  | 17 INFORMANT ADDRESS  |  |  |  |   |  |  |  |
| NO  |  | 219 40 8748   |  | ROBT. VITEK   |  | ABOVE  |  |   |  |  |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 4149 cardiac arrest  |  |   |  |   |  |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| DUE TO, OR AS A CONSEQUENCE OF (b) coronary disease   |  |   |  |   |  |  |  |   |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF (c)  |  |   |  |   |  |  |  |   |  |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |   |  |   |  |  |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>                       |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M.   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |   |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                 |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |  |  |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 2/16/82 to 2/16/82, that (I) (we) last saw the deceased alive on 2/16/82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  | 22b. SIGNATURE Lucien Levy MD   |  | 22c. DATE SIGNED 2/16   |  |  |  |   |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  | 22e. ADDRESS  |  |   |  |  |  |   |  |  |  |
| LUCIEN LEVY   |  | BCH   |  |   |  |  |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |  | 23b. DATE   |  | 23c. NAME OF CEMETERY OR CREMATORY  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE  |  |   |  |  |  |
| BURIAL  |  | 2/19/82   |  | GARDENS OF FAITH  |  | BALTO. MD.   |  |   |  |  |  |
| 24 FUNERAL DIRECTOR NAME  |  | 24b. ADDRESS  |  | 25a. DATE REC'D. BY REGISTRAR   |  | 25b. REGISTRAR'S SIGNATURE   |  |   |  |  |  |
| J. G. CONNELLY  |  | 300 MACE  |  | FEB 17 1982   |  | Name   |  |   |  |  |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after burial, cremation, or removal.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 3 and 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified in case 300

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |   |   |  |  |  |  |
|--|--|--|--|---|---|--|--|--|--|
| 1. FOR<br>STATE<br>REGISTRAR   |  | REG. NO. 8 2 0 4 2 9 0   |  |   |   |  |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>LETTIE W. VOGEL   |  |  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>2 7 82 |  |  | 2b. HOUR<br>3 20 A M   |  |
| 3. SEX<br>Female   |  | 4. RACE<br>White   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>Oct 12, 1896  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>85 YRS  |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Virginia  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>KESWICK |  |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Clerk  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13a. STATE<br>Maryland   |  | 13b. COUNTY  |  | 13c. CITY OR TOWN<br>Baltimore  |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 13e. STREET ADDRESS<br>2315 N. Charles Street  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>James B. Williams  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Theba Edwards   |  |   |   |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>212-22-8986   |  | 17. INFORMANT<br>ADDRESS<br>Mary Collins 5660 Woodmont Ave. Baltimore   |   |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) 4100 Coronary Thrombosis<br>DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic Coronary artery disease<br>DUE TO, OR AS A CONSEQUENCE OF (c)<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. |  |  |  |   |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>1 1/2 years.   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |  |  |   |   |  |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |   |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 1-29 1968, to 2-7 1982, that (I) (we) lost saw the deceased alive on 2-7 1982, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.   |  |  |  |   |   |  |  |  |  |
| 22b. SIGNATURE<br>Shelly H. Jones  |  |  |  | DEGREE  |   | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  |  |  | 22e. ADDRESS  |   |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Cremation  |  | 23b. DATE<br>Feb. 8, 1982  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Green Mount Crematory   |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore Maryland   |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Leonard J. Ruck, Inc. Baltimore, Maryland  |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br>FEB 8 1982   |   | 25b. REGISTRAR'S SIGNATURE<br>Thane J. [Signature]   |  |  |  |



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  | REG. NO. 8 2 0 4 2 9 1  |  |   |  |
|--|--|--|--|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Carrie v. Vogt</b>  |  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR <b>2-8-1982</b>  |  |   |  |
| 3. SEX <b>Female</b>   |  |  |  | 2b. HOUR <b>12:20</b> P M   |  |   |  |
| 4. RACE <b>White</b>   |  | 5. DATE OF BIRTH MONTH DAY YEAR <b>6 10 91</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY) <b>90</b> YRS   |  | IF UNDER 1 YEAR MONTHS DAYS   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Md.</b>   |  | 7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.  |  |
| 10. CITY OR TOWN OF DEATH <b>Baltimore</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Belair Convalesarium</b> |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Seamstress - Nurses Uniform</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |   |  |
| 13a. STATE <b>Md.</b>  |  | 13b. COUNTY <b>-</b>   |  | 13c. CITY OR TOWN <b>Balto.</b>   |  | 13e. STREET ADDRESS <b>4704 Antanna Ave. 21206</b>  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST <b>Leonard Eisinger</b>  |  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Caroline</b>  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b>  |  | 16b. SOCIAL SECURITY NO. <b>219-07-3435</b>  |  | 17. INFORMANT ADDRESS <b>Joseph C. Vogt 4917 Lasalle Ave.</b>   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARDIAC ARREST</b><br>4409<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:<br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>ARTERIOSCLEROSIS, GENERALIZED</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>CHRONIC CONGESTIVE HEART FAILURE</b><br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <b>FAILURE</b> |  |  |  |   |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |   |  |
| 22a. I certify that (I) (the hospital) attended the deceased from <b>6/3</b> , 19 <b>77</b> , to <b>2/8/</b> , 19 <b>82</b> , that (I) (we) last saw the deceased alive on <b>2/8/82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.  |  |  |  |   |  |   |  |
| 22b. SIGNATURE <b>[Signature]</b> DEGREE   |  |  |  | ATTENDING MEDICAL STAFF PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/>   |  | 22c. DATE SIGNED <b>2/9/82</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Luis E. Rivera, M.D.</b>  |  |  |  | 22e. ADDRESS <b>50 Scott Adam Road Cockeysville, Maryland 21030</b>   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>  |  | 23b. DATE <b>2-11-82</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY <b>Parkwood Cem.</b>   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE <b>Balto. Md.</b>   |  |
| 24. FUNERAL DIRECTOR NAME <b>John C. Miller Inc. 6415 Belair Rd.</b> ADDRESS   |  |  |  | 25a. DATE REC'D. BY REGISTRAR <b>FEB 11 1982</b> REGISTRAR'S SIGNATURE <b>[Signature]</b>   |  |   |  |

MEDICAL CERTIFICATION

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2/8

50 South Adams Road

Coe, Nevada, 89400

Miss E. Rivers, M.D.

FEB 11 1982

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed and retained by the hospital or attending physician.

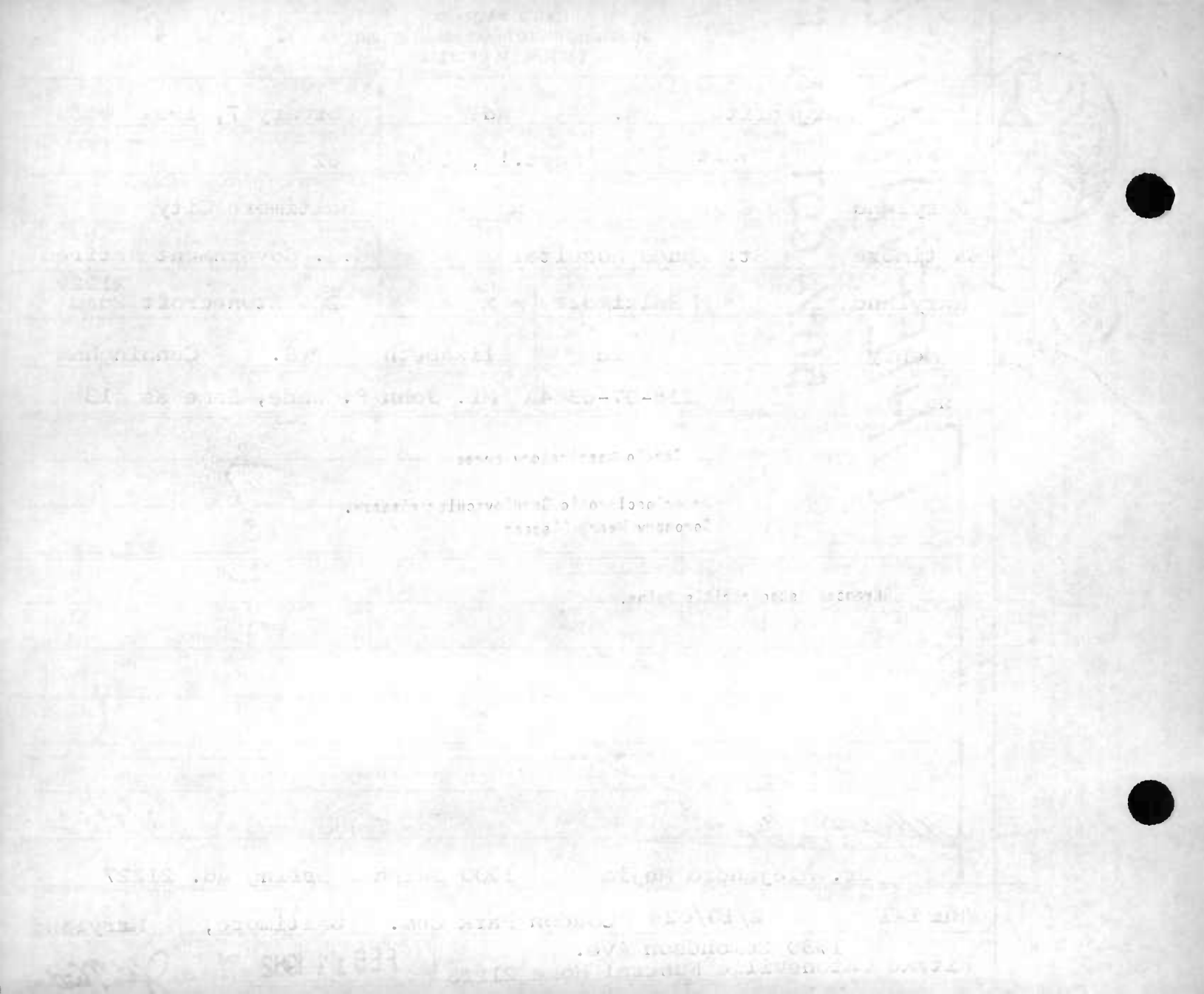
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  |   | REG. NO. 8 2 0 4 2 9 2   |  |  |  |   |  |
|---|--|--|--|---|--|--|--|--|---|--|
| 1- FOR STATE REGISTRAR  |  |  |  |   | 2a. DATE OF DEATH MONTH DAY YEAR 2b. HOUR A M  |  |  |  |   |  |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br>Marguerite A. Wade  |  |  |  |   | February 7, 1982 0639 M  |  |  |  |   |  |
| 3. SEX<br>Female  |  | 4. RACE<br>White   |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>Sept. 12, 1899   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>82 YRS  |  | 7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U S A  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.                       |  |  |   |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>St. Agnes Hospital |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>U.S. Government |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Retired               |   |  |
| 13a. STATE<br>Maryland  |  |  |  |   | 13b. COUNTY<br>Baltimore   |  | 13c. CITY OR TOWN<br>Baltimore   |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>Henry Ward   |  |  |  |   | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Elizabeth S. Cunningham  |  |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>no   |  |  |  |   | 16b. SOCIAL SECURITY NO.<br>218-07-8364A   |  | 17. INFORMANT ADDRESS<br>Mr. John P. Wade, Same as #13                 |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>4149 Cardio Respiratory arrest</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Arteriosclerotic Cardiovascular disease.</u><br>DUE TO, (c) <u>Coronary Heart Disease</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last |  |  |  |   |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. (a)<br><u>Advanced Osteoarthritis Spine.</u>   |  |  |  |   |  |  |  |  |   |  |
| 19a. DATE OF OPERATION  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED               |   |  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)  |  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19        |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  |  | 21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.) |   | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |  |  |   |  |  |  |  |   |  |
| 22b. SIGNATURE<br><u>Dr. Alejandro Mejia</u>  |  |  |  |   | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  |  | 22c. DATE SIGNED<br>2/7/82                                 |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Dr. Alejandro Mejia  |  |  |  |   | 22e. ADDRESS<br>1900 Sulphur Spring Rd. 21227  |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial   |  | 23b. DATE<br>2/10/82   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Loudon Park Cem.  |  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>Baltimore, Maryland         |  |   |  |
| 24. FUNERAL DIRECTOR NAME<br>Witzke Catonsville Funeral Home 21228  |  |  |  |   | 25a. DATE REC'D. BY REGISTRAR<br>FEB 11 1982   |  |  | 25b. REGISTRAR'S SIGNATURE<br><u>Thomas Van Natten</u>     |   |  |





TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of cause.

| Item #4 Film G564 2/22/82 rc   |  |  |  | STATE OF MARYLAND   |  |  |  |
|--|--|--|--|---|--|--|--|
| 1. FOR STATE REGISTRAR   |  |  |  | DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |  |  |
| CERTIFICATE OF DEATH   |  |  |  | REG. NO. 8 2 0 4 2 9 3  |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br><b>JAQUELYN WAFER</b>   |  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>FEBRUARY 14 1982</b>   |  | 2b. HOUR<br><b>2:53A.M.</b>  |  |
| 3. SEX<br><b>Female</b>  |  | 4. RACE<br><b>White</b>  |  | 5. DATE OF BIRTH 21st<br>MONTH DAY YEAR<br><b>7 26 48</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>33</b> YRS<br># UNDER 1 YEAR MONTHS DAYS<br># UNDER 24 HRS. HOURS MIN.               |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>JOHNS HOPKINS HOSPITAL</b> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Staff Assoc.</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>C.&amp;P. Teleph.</b>  |  |
| 13a. STATE<br><b>Maryland</b>  |  |  |  | 13b. CITY OR TOWN<br><b>Howard Ellicott City</b>  |  | 13c. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input type="checkbox"/> NO                                       |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Denard A. Lokey</b>   |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Madelyn G. Smith</b>  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>217-52-1966</b>   |  | 17. INFORMANT ADDRESS<br><b>Mr. John D. Wafer Same as # 13</b>  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>RESPIRATORY DISTRESS</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>WBG metastasis and hilot. pleural effusion</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>Metastatic heart carcinoma</b><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |  |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a)<br><b>Central nervous system and bone metastases</b>  |  |  |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) lost<br>saw the deceased alive on <b>Feb 14th</b> 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.                               |  |  |  |   |  |  |  |
| 22b. SIGNATURE<br><b>Luis F. Gimenez</b>   |  | DEGREE<br><b>M.D.</b>  |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>                  |  | 22c. DATE SIGNED<br><b>2/14/82</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>LUIS F. GIMENEZ</b>  |  | 22e. ADDRESS<br><b>600 N. WOLFE STREET BALTO MD 21205</b>  |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Cremation</b>   |  | 23b. DATE<br><b>2/17/82</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Westview Crematory</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Catonsville Md.</b>   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Witzke Columbia Funeral Home</b>  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>FEB 16 1982</b>  |  | REGISTRAR'S SIGNATURE<br><b>James J. Nathan</b>   |  |  |  |
| 25b. ADDRESS<br><b>5555 Twin Knolls Rd. Columbia, Md. 21045</b>  |  |  |  |   |  |  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death and retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  | 8 2 0 4 2 9 4   |  |  |  |
|---|--|---|--|---|--|--|--|
| FOR<br>1 - STATE<br>REGISTRAR   |  |   |  | REG. NO.  |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br><b>MARY WALKER</b>   |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>FEBRUARY 28, 1982</b>  |  | 2b. HOUR<br><b>8:40 pm</b>   |  |
| 3. SEX<br><b>female</b>   |  | 4. RACE<br><b>Black</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>9 13 16</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>65</b>   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Virginia</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>US</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>CITY</b>  |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>CHURCH HOSPITAL</b> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>RETIRED</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>MARYLAND</b>  |  |   |  | 13b. COUNTY<br><b>BALTIMORE</b>   |  | 13c. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>CHARLIE MACK</b>   |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>DORTHY</b>  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>   |  | 16b. SOCIAL SECURITY NO.  |  | 17. INFORMANT ADDRESS<br><b>JOHN DURHAM 1217 SILVERTHORNE RD.</b>   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>VENTRICULAR FIBRILLATION</b><br>4100 } DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>MYOCARDIAL INFARCTION</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |   |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)<br><b>HISTORY OF MYOCARDIAL INFARCTION (TRUE POSTERIOR)</b>  |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>2/28/1982</b> , to <b>2/28/1982</b> , that (I) (we) lost<br>saw the deceased alive on <b>2/28/1982</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.  |  |   |  |   |  |  |  |
| 22b. SIGNATURE<br><i>[Signature]</i>  |  | DEGREE<br><b>M.D.</b>   |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>                  |  | 22c. DATE SIGNED<br><b>2/28/82</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>V. SILVER M.D.</b>  |  | 22e. ADDRESS<br><b>Church Hospital, MD 21231</b>  |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br><b>REMOVAL</b>   |  | 23b. DATE<br><b>3-3-82</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>CENTER UNION CH. CEM.</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>CUMBERLAND MARYLAND</b>   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>E.L. PHILLIPS</b>  |  |   |  | 25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE<br><b>MAR 4 1982 Frances Jan. Thirten</b>  |  |  |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DHMH - 16 3/72 25M  
(VR A15 (4))

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

|  |  |  |   |   |   |   |  |                                    |  |
|--|--|--|---|---|---|---|--|------------------------------------|--|
| 1. DECEASED-NAME<br>(Type or print) <u>Nancy C. Walker</u>   |  |  | 2a. DATE OF DEATH<br>Month <u>2</u> Day <u>28</u> Year <u>82</u>                                    |   |   | 2b. HOUR<br><u>2:10</u> M   |  |                                    |  |
| 3. SEX<br><u>F</u>   |  | 4. RACE<br><u>B</u>  |   | 5. DATE OF BIRTH<br><u>10/12/95</u>   |   | 6. AGE (In years last birthday)<br><u>86</u> YRS.   |  |                                    |  |
| 7a. BIRTHPLACE (State or foreign country)<br><u>N.C.</u>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.</u>                                |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. COUNTY OF DEATH<br><u>City</u> Md.   |  |                                    |  |
| 10. CITY OR TOWN OF DEATH<br><u>Baltimore</u>  |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><u>Granada N.H.</u> |   |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)     |  |                                    |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><u>Md</u>   |  |  | 13b. COUNTY<br><u>Balto.</u>  |   | 13c. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   | 13e. STREET AND NUMBER<br><u>3816 Bonner Rd.</u>                     |                                    |  |
| 14. FATHER'S NAME First Middle Last<br><u>Hibert</u> <u>Herring</u>  |  |  | 15. MOTHER'S MAIDEN NAME First Middle Last<br><u>Sennie</u> <u>Loyals</u>                           |   |   |   |  |                                    |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) (If yes give war or dates of service)  |  |  | 16b. SOCIAL SECURITY NO.<br><u>220-22-1840</u>  |   | 17. INFORMANT<br><u>Bernice Smith</u> Address <u>3816 Bonner Rd.</u>                            |   |  |                                    |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardio pulmonary arrest</u><br><u>4292</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) <u>ASCVD</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) |  |  |   |   |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                         |                                    |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |                                    |  |
| 21a. ACCIDENT WAS OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)   |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <u>19</u>            |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |   |   |  |                                    |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |   | 21f. LOCATION Street or R.F.D. No. City or Town County State  |   |   |  |                                    |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>2-15</u> , 19 <u>82</u> to <u>2-28</u> , 19 <u>82</u> , that (I) (we) last saw the deceased alive on <u>2-28</u> , 19 <u>82</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.   |  |  |   |   |   |   |  | 22c. DATE SIGNED<br><u>2-28-82</u> |  |
| 22b. SIGNATURE<br><u>[Signature]</u>   |  | 22d. PHYSICIAN'S NAME (Type)<br><u>MD</u>                                    |   | 22e. ADDRESS  |   | 22f. MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/> |  |                                    |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>   |  | 23b. DATE<br><u>3/4/82</u>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Arbutus Mem. Pk.</u>   |   | 23d. LOCATION (City or Town) (County) (State)<br><u>Arbutus, Md.</u>                        |  |                                    |  |
| 24. FUNERAL DIRECTOR<br><u>Wm C March F/H, Inc.</u>  |  |  |   | 25a. REC'D BY REGISTRAR<br>DATE <u>MAR 1 1982</u>   |   | 25b. REGISTRAR'S SIGNATURE<br><u>[Signature]</u>  |  |                                    |  |

CHIEF TALKER

NO 102 6800

RECEIVED  
OFFICE OF THE  
DIRECTOR OF THE  
BUREAU OF THE  
INDIAN AFFAIRS  
WASHINGTON, D.C.



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 4 2 9 6

REG. NO.

1. FOR  
STATE  
REGISTRAR

|   |  |                        |   |   |  |   |  |   |   |  |
|---|--|------------------------|---|---|--|---|--|---|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Irane M. Wall</b>                                    |  |                        | 2a. DATE OF DEATH MONTH <b>02</b> DAY <b>02</b> YEAR <b>82</b>  |   |  | 2b. HOUR <b>10<sup>30</sup> PM</b>  |  |   |   |  |
| 3 SEX <b>F-Female</b>   |  | 4. RACE <b>C-White</b> |   | 5. DATE OF BIRTH MONTH <b>4</b> DAY <b>5</b> YEAR <b>04</b> |  | 6. AGE (IN YEARS LAST BIRTHDAY) <b>77</b> YRS.  |  | 7. IF UNDER 1 YEAR MONTHS <b></b> DAYS <b></b> HOURS <b></b> MIN. |   |  |
| 8. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Md Baltimore</b>                                |  |                        | 9. CITIZEN OF WHAT COUNTRY? <b>USA</b>  |   |  | 10. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.                             |  |   | 11. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |
| 12. CITY OR TOWN OF DEATH <b>Balto.</b>   |  |                        | 13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>John L. Deaton Med. Ck.</b> |   |  | 14. USUAL OCCUPATION (TYPE OF WORK OR MOST OF WORKING LIFE) <b>Chart Clerk</b>              |  |   | 15. KIND OF BUSINESS OR INDUSTRY <b>Dry Cleaning</b>  |  |
| 16. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) |  |                        | 17. STATE <b>Md.</b> COUNTY <b>Balto.</b> CITY OR TOWN <b>Baltimore</b>   |   |  | 18. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |   | 19. STREET ADDRESS <b>7828 Gough Street</b>   |  |
| 20. FATHER'S NAME FIRST <b>Thomas</b> MIDDLE <b>J.</b> LAST <b>Coughlin</b>                 |  |                        | 21. MOTHER'S MAIDEN NAME FIRST <b>Katherine</b> MIDDLE <b>Young</b> LAST <b></b>  |   |  | 22. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>                  |  |   | 23. SOCIAL SECURITY NO. <b>215-24-3611</b>  |  |
| 24. INFORMANT <b>Baltimore, Md. 21224.</b>  |  |                        | 25. ADDRESS <b>Mr. Edward R. Wall-225 N. Kenwood Ave</b>  |   |  | 26. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)                   |  |   | 27. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART 1. DEATH WAS CAUSED BY:  
IMMEDIATE CAUSE (a) **Respiratory failure 20 pneumonia**  
DUE TO, OR AS A CONSEQUENCE OF **hypertension**  
(b) **Diabetes mellitus, multiple**  
DUE TO, OR AS A CONSEQUENCE OF **CVA & MI hemiparesis**  
(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

|   |  |   |  |  |  |   |  |
|---|--|---|--|--|--|---|--|
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                    |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>         |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>         |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                 |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>Feb 2</b> 19 <b>82</b> to <b>Feb 2</b> 19 <b>82</b> , that (I) (we) lost saw the deceased alive on <b>Feb 2</b> 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |  |  |  |   |  |
| 22b. SIGNATURE <b>JULIAN W. REED</b> DEGREE <b></b> ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>  |  |   |  | 22c. DATE SIGNED <b>2/3/82</b>   |  |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>JULIAN W. REED MD</b>  |  |   |  | 22e. ADDRESS <b>5115 CHAS. ST BALTO. MD 21231</b>                              |  |   |  |

|  |  |                               |  |   |  |   |  |
|--|--|-------------------------------|--|---|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>                                    |  | 23b. DATE <b>Feb. 6, 1982</b> |  | 23c. NAME OF CEMETERY OR CREMATORY <b>Oak Lawn Cemetery Baltimore, Maryland</b> |  | 23d. LOCATION CITY OR TOWN COUNTY STATE           |  |
| 24. FUNERAL DIRECTOR NAME <b>John St. Moran, Inc.</b> ADDRESS <b>3000 E. Baltimore St.</b> |  |                               |  | 25a. DATE REC'D. BY REGISTRAR <b>FEB 8 1982</b>                                 |  | 25b. REGISTRAR'S SIGNATURE <b>James O. Nathan</b> |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove this certificate from the file and return it to the State Department of Health and Mental Hygiene prior to burial, cremation or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

RECEIVED BY THE  
UNITED STATES DEPARTMENT OF THE ARMY  
WASHINGTON, D. C. 20315

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 4 2 9 7

1- FOR  
STATE  
REGISTRAR

REG. NO.

|   |  |   |  |  |  |  |  |   |  |
|---|--|---|--|--|--|--|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Randy G. Wall</b>  |  |   | 2a. DATE OF DEATH MONTH <b>2</b> DAY <b>13</b> YEAR <b>1982</b>                    |  |  | 2b. HOUR <b>9:15</b> AM  |  |   |  |
| 3 SEX <b>Female</b>   |  | 4 RACE <b>Black</b>   |  | 5. DATE OF BIRTH<br>MONTH <b>3</b> DAY <b>25</b> YEAR <b>1891</b>  |  | 6 AGE (IN YEARS LAST BIRTHDAY) <b>90</b>   |  | 7b. HOUR <b>9:15</b> AM   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>North Carolina</b>   |  | 7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>  |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.   |  |   |  |
| 10 CITY OR TOWN OF DEATH <b>Baltimore</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Provident Hosp</b> |  |  |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)   |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE <b>MD</b>  |  |   | 13b. COUNTY <b>Balto</b>   |  | 13c. CITY OR TOWN <b>Balto</b>   |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   |  |
| 14 FATHER'S NAME<br>FIRST <b>Mike</b> MIDDLE <b>Green</b> LAST <b>Green</b>   |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>Ann</b> MIDDLE <b>Green</b> LAST <b>Green</b> |  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>  |  |   |  |
| 16b. SOCIAL SECURITY NO.  |  |   | 17 INFORMANT <b>Minnie Johnson</b>   |  |  | ADDRESS <b>3913 Chatham Rd.</b>  |  |   |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiovascular Arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Septicemia</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Generalized Osteoporotic Lesions</b>   |  |   |  |  |  |  |  |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br><b>10 min</b><br><b>1 week</b><br><b>20 years</b> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |   |  |  |  |  |  |   |  |
| 19a. DATE OF OPERATION  |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                   |  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                         |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)             |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |  |   |  |
| 22a. I certify that (1) this hospital attended the deceased from <b>Jan 6</b> 19 <b>82</b> , to <b>Feb 3</b> 19 <b>82</b> , that (1) (we) last saw the deceased alive on <b>Feb 3</b> 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (and) (did not) view the body after death. |  |   |  |  |  |  |  |   |  |
| 22b. SIGNATURE <b>A. Miranda</b>  |  |   | DEGREE <b>MD</b>   |  |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED <b>2/3/82</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>A. MIRANDA</b>   |  |   | 22e. ADDRESS <b>PROVIDENT HOSPITAL</b>   |  |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>   |  |   | 23b. DATE <b>2/6/82</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY <b>Mt Auburn</b>                            |  | 23d. LOCATION<br>CITY OR TOWN <b>Balto</b> COUNTY <b>MD</b> STATE                            |   |  |
| 24. FUNERAL DIRECTOR<br>NAME <b>Leroy O. Sytt</b> ADDRESS <b>4600 Liberty</b>   |  |   | 25a. DATE REC'D. BY REGISTRAR <b>FEB 8 1982</b>                                    |  | 25b. REGISTRAR'S SIGNATURE <b>Thom J. Martin</b>                               |  |  |   |  |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

|     |  |      |    |    |    |    |    |         |    |
|-----|--|------|----|----|----|----|----|---------|----|
| No. |  | Date |    | To |    | By |    | Remarks |    |
| 1   |  | 1917 | 10 | 10 | 10 | 10 | 10 | 10      | 10 |
| 2   |  | 1917 | 10 | 10 | 10 | 10 | 10 | 10      | 10 |
| 3   |  | 1917 | 10 | 10 | 10 | 10 | 10 | 10      | 10 |
| 4   |  | 1917 | 10 | 10 | 10 | 10 | 10 | 10      | 10 |
| 5   |  | 1917 | 10 | 10 | 10 | 10 | 10 | 10      | 10 |
| 6   |  | 1917 | 10 | 10 | 10 | 10 | 10 | 10      | 10 |
| 7   |  | 1917 | 10 | 10 | 10 | 10 | 10 | 10      | 10 |
| 8   |  | 1917 | 10 | 10 | 10 | 10 | 10 | 10      | 10 |
| 9   |  | 1917 | 10 | 10 | 10 | 10 | 10 | 10      | 10 |
| 10  |  | 1917 | 10 | 10 | 10 | 10 | 10 | 10      | 10 |
| 11  |  | 1917 | 10 | 10 | 10 | 10 | 10 | 10      | 10 |
| 12  |  | 1917 | 10 | 10 | 10 | 10 | 10 | 10      | 10 |
| 13  |  | 1917 | 10 | 10 | 10 | 10 | 10 | 10      | 10 |
| 14  |  | 1917 | 10 | 10 | 10 | 10 | 10 | 10      | 10 |
| 15  |  | 1917 | 10 | 10 | 10 | 10 | 10 | 10      | 10 |
| 16  |  | 1917 | 10 | 10 | 10 | 10 | 10 | 10      | 10 |
| 17  |  | 1917 | 10 | 10 | 10 | 10 | 10 | 10      | 10 |
| 18  |  | 1917 | 10 | 10 | 10 | 10 | 10 | 10      | 10 |
| 19  |  | 1917 | 10 | 10 | 10 | 10 | 10 | 10      | 10 |
| 20  |  | 1917 | 10 | 10 | 10 | 10 | 10 | 10      | 10 |
| 21  |  | 1917 | 10 | 10 | 10 | 10 | 10 | 10      | 10 |
| 22  |  | 1917 | 10 | 10 | 10 | 10 | 10 | 10      | 10 |
| 23  |  | 1917 | 10 | 10 | 10 | 10 | 10 | 10      | 10 |
| 24  |  | 1917 | 10 | 10 | 10 | 10 | 10 | 10      | 10 |
| 25  |  | 1917 | 10 | 10 | 10 | 10 | 10 | 10      | 10 |
| 26  |  | 1917 | 10 | 10 | 10 | 10 | 10 | 10      | 10 |
| 27  |  | 1917 | 10 | 10 | 10 | 10 | 10 | 10      | 10 |
| 28  |  | 1917 | 10 | 10 | 10 | 10 | 10 | 10      | 10 |
| 29  |  | 1917 | 10 | 10 | 10 | 10 | 10 | 10      | 10 |
| 30  |  | 1917 | 10 | 10 | 10 | 10 | 10 | 10      | 10 |
| 31  |  | 1917 | 10 | 10 | 10 | 10 | 10 | 10      | 10 |
| 32  |  | 1917 | 10 | 10 | 10 | 10 | 10 | 10      | 10 |
| 33  |  | 1917 | 10 | 10 | 10 | 10 | 10 | 10      | 10 |
| 34  |  | 1917 | 10 | 10 | 10 | 10 | 10 | 10      | 10 |
| 35  |  | 1917 | 10 | 10 | 10 | 10 | 10 | 10      | 10 |
| 36  |  | 1917 | 10 | 10 | 10 | 10 | 10 | 10      | 10 |
| 37  |  | 1917 | 10 | 10 | 10 | 10 | 10 | 10      | 10 |
| 38  |  | 1917 | 10 | 10 | 10 | 10 | 10 | 10      | 10 |
| 39  |  | 1917 | 10 | 10 | 10 | 10 | 10 | 10      | 10 |
| 40  |  | 1917 | 10 | 10 | 10 | 10 | 10 | 10      | 10 |
| 41  |  | 1917 | 10 | 10 | 10 | 10 | 10 | 10      | 10 |
| 42  |  | 1917 | 10 | 10 | 10 | 10 | 10 | 10      | 10 |
| 43  |  | 1917 | 10 | 10 | 10 | 10 | 10 | 10      | 10 |
| 44  |  | 1917 | 10 | 10 | 10 | 10 | 10 | 10      | 10 |
| 45  |  | 1917 | 10 | 10 | 10 | 10 | 10 | 10      | 10 |
| 46  |  | 1917 | 10 | 10 | 10 | 10 | 10 | 10      | 10 |
| 47  |  | 1917 | 10 | 10 | 10 | 10 | 10 | 10      | 10 |
| 48  |  | 1917 | 10 | 10 | 10 | 10 | 10 | 10      | 10 |
| 49  |  | 1917 | 10 | 10 | 10 | 10 | 10 | 10      | 10 |
| 50  |  | 1917 | 10 | 10 | 10 | 10 | 10 | 10      | 10 |
| 51  |  | 1917 | 10 | 10 | 10 | 10 | 10 | 10      | 10 |
| 52  |  | 1917 | 10 | 10 | 10 | 10 | 10 | 10      | 10 |
| 53  |  | 1917 | 10 | 10 | 10 | 10 | 10 | 10      | 10 |
| 54  |  | 1917 | 10 | 10 | 10 | 10 | 10 | 10      | 10 |
| 55  |  | 1917 | 10 | 10 | 10 | 10 | 10 | 10      | 10 |
| 56  |  | 1917 | 10 | 10 | 10 | 10 | 10 | 10      | 10 |
| 57  |  | 1917 | 10 | 10 | 10 | 10 | 10 | 10      | 10 |
| 58  |  | 1917 | 10 | 10 | 10 | 10 | 10 | 10      | 10 |
| 59  |  | 1917 | 10 | 10 | 10 | 10 | 10 | 10      | 10 |
| 60  |  | 1917 | 10 | 10 | 10 | 10 | 10 | 10      | 10 |
| 61  |  | 1917 | 10 | 10 | 10 | 10 | 10 | 10      | 10 |
| 62  |  | 1917 | 10 | 10 | 10 | 10 | 10 | 10      | 10 |
| 63  |  | 1917 | 10 | 10 | 10 | 10 | 10 | 10      | 10 |
| 64  |  | 1917 | 10 | 10 | 10 | 10 | 10 | 10      | 10 |
| 65  |  | 1917 | 10 | 10 | 10 | 10 | 10 | 10      | 10 |
| 66  |  | 1917 | 10 | 10 | 10 | 10 | 10 | 10      | 10 |
| 67  |  | 1917 | 10 | 10 | 10 | 10 | 10 | 10      | 10 |
| 68  |  | 1917 | 10 | 10 | 10 | 10 | 10 | 10      | 10 |
| 69  |  | 1917 | 10 | 10 | 10 | 10 | 10 | 10      | 10 |
| 70  |  | 1917 | 10 | 10 | 10 | 10 | 10 | 10      | 10 |
| 71  |  | 1917 | 10 | 10 | 10 | 10 | 10 | 10      | 10 |
| 72  |  | 1917 | 10 | 10 | 10 | 10 | 10 | 10      | 10 |
| 73  |  | 1917 | 10 | 10 | 10 | 10 | 10 | 10      | 10 |
| 74  |  | 1917 | 10 | 10 | 10 | 10 | 10 | 10      | 10 |
| 75  |  | 1917 | 10 | 10 | 10 | 10 | 10 | 10      | 10 |
| 76  |  | 1917 | 10 | 10 | 10 | 10 | 10 | 10      | 10 |
| 77  |  | 1917 | 10 | 10 | 10 | 10 | 10 | 10      | 10 |
| 78  |  | 1917 | 10 | 10 | 10 | 10 | 10 | 10      | 10 |
| 79  |  | 1917 | 10 | 10 | 10 | 10 | 10 | 10      | 10 |
| 80  |  | 1917 | 10 | 10 | 10 | 10 | 10 | 10      | 10 |
| 81  |  | 1917 | 10 | 10 | 10 | 10 | 10 | 10      | 10 |
| 82  |  | 1917 | 10 | 10 | 10 | 10 | 10 | 10      | 10 |
| 83  |  | 1917 | 10 | 10 | 10 | 10 | 10 | 10      | 10 |
| 84  |  | 1917 | 10 | 10 | 10 | 10 | 10 | 10      | 10 |
| 85  |  | 1917 | 10 | 10 | 10 | 10 | 10 | 10      | 10 |
| 86  |  | 1917 | 10 | 10 | 10 | 10 | 10 | 10      | 10 |
| 87  |  | 1917 | 10 | 10 | 10 | 10 | 10 | 10      | 10 |
| 88  |  | 1917 | 10 | 10 | 10 | 10 | 10 | 10      | 10 |
| 89  |  | 1917 | 10 | 10 | 10 | 10 | 10 | 10      | 10 |
| 90  |  | 1917 | 10 | 10 | 10 | 10 | 10 | 10      | 10 |
| 91  |  | 1917 | 10 | 10 | 10 | 10 | 10 | 10      | 10 |
| 92  |  | 1917 | 10 | 10 | 10 | 10 | 10 | 10      | 10 |
| 93  |  | 1917 | 10 | 10 | 10 | 10 | 10 | 10      | 10 |
| 94  |  | 1917 | 10 | 10 | 10 | 10 | 10 | 10      | 10 |
| 95  |  | 1917 | 10 | 10 | 10 | 10 | 10 | 10      | 10 |
| 96  |  | 1917 | 10 | 10 | 10 | 10 | 10 | 10      | 10 |
| 97  |  | 1917 | 10 | 10 | 10 | 10 | 10 | 10      | 10 |
| 98  |  | 1917 | 10 | 10 | 10 | 10 | 10 | 10      | 10 |
| 99  |  | 1917 | 10 | 10 | 10 | 10 | 10 | 10      | 10 |
| 100 |  | 1917 | 10 | 10 | 10 | 10 | 10 | 10      | 10 |

(12)



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

1. FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 4 2 9 8  
REG. NO.

|   |  |   |  |   |  |
|---|--|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>FRANKIE R. WALL RATH</b>   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>2/5/82</b>                               |   | 2b. HOUR<br>M  |
| 3. SEX<br><b>MALE</b>   | 4. RACE<br><b>CAUC.</b>  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>8/20/25</b>  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>56</b> YRS.                                  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.   |  |
| 7a. BIRTHPLACE<br>COUNTRY<br><b>N.Y.</b>  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.</b>  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>         | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTO CITY</b> MD.                      |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTO</b>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>GOOD SAMITAN HOSP.</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>RETIRED</b> | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>MD.</b>  |  | 13b. COUNTY   | 13c. CITY OR TOWN<br><b>BALTO.</b>   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS<br><b>100 W. COLD SPRING CA.</b>   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>YES</b>  |  | 16b. SOCIAL SECURITY NO.<br>(IF GIVE WAR OR DATES)<br><b>WW 2 243-182696</b>  |  | 17. INFORMANT<br>ADDRESS<br><b>WIFE</b>   |  |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Coronary Vascular collapse.</b><br>2500<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Acute Renal failure.</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Complication of Diabetes mellitus.</b><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |   |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I:  |  |   |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)      |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>11/5/82</b> to <b>2/5/82</b> , that (I) (we) lost saw the deceased alive on <b>11/5/82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |   |  |   |  |
| 22b. SIGNATURE<br><b>Rhughal</b>  |  | DEGREE <b>Home Staff, MD.</b><br>ATTENDING MEDICAL STAFF<br>PHYSICIAN <input type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>BEENA NAGPAL</b>  |  | 22e. ADDRESS  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>   | 23b. DATE<br><b>2/9/82</b>   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>WOODLAWN</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>BALTO. MD.</b>                                 |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Carl E. Chonoweth</b>  |  | ADDRESS<br><b>3617 Chestnut St.</b>   |  | 25a. DATE BY REGISTERED<br><b>FEB 9 1982</b>  |  |





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16-50M 1/81  
(VRA 15, 4)

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |   |  |  |  |  |   |  |
|---|--|--|---|--|--|--|--|---|--|
| 1. FOR STATE REGISTRAR  |  |  |   |  | REG. NO. 8 2 0 4 2 9 9   |  |  |   |  |
| 1. DECEASED NAME (TYPE OR PRINT) <b>JOHN FRANCIS WALSH</b>  |  |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR <b>02/24/82</b>   |  |  | 2b. HOUR <b>8:22 am</b>   |  |
| 3. SEX <b>Male</b>  |  | 4. RACE <b>White</b>   |   | 5. DATE OF BIRTH MONTH DAY YEAR <b>Aug. 15, 1926</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY) <b>55</b> YRS.   |  | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Phila., Pa.</b>  |  | 7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>   |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY, MD.</b>                              |  |   |  |
| 10. CITY OR TOWN OF DEATH <b>BALTO., CITY</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>St. Agnes Hospital</b> |   |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Salesman</b>                |  | 12b. KIND OF BUSINESS OR INDUSTRY <b>Trucking Firm</b>  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |  |   |  | 13a. STREET ADDRESS  |  |  |   |  |
| 13a. STATE <b>Md.</b>   |  | 13b. COUNTY <b>----</b>  |   | 13c. CITY OR TOWN <b>Baltimore</b>   |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS <b>5105 Edmondson Avenue</b>  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST <b>Francis Michael Walsh</b>  |  |  |   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Eileen O'Keefe</b>   |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>  |  |  |   |  | 16b. SOCIAL SECURITY NO. <b>WW 11 117-20-6074</b>  |  | 17. INFORMANT <b>Baltimore, Md. 21229. Mrs. Mary Clare Walsh-5105 Edmondson Ave.</b> |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIAC ARREST</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>MYOCARDIAL INFARCTION</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>4100</b>  |  |  |   |  |  |  |  |   |  |
| PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)  |  |  |   |  |  |  |  |   |  |
| 19a. DATE OF OPERATION  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                    |  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>                       |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>2/24 19 82 P.M.</b> |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B: PART 1 OR PART 2)               |  |   |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |   |  |
| 22a. I certify that (he) (this hospital) attended the deceased from <b>2/24 19 82</b> , to <b>2/24 19 82</b> , that (he) (we) lost saw the deceased alive on <b>2/24 19 82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) (did) (did not) view the body after death. |  |  |   |  |  |  |  |   |  |
| 22b. SIGNATURE <b>Geetha Raja</b>   |  |  |   |  | DEGREE <b>RESIDENT</b> ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  |  | 22c. DATE SIGNED <b>2/24/82</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>GEETHA RAJA</b>  |  |  |   |  | 22e. ADDRESS   |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial Feb. 27, 1982</b>   |  |  | 23b. DATE   |  |  | 23c. NAME OF CEMETERY OR CREMATORY <b>New Cathedral Cemetery</b>                             |  | 23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore, Md.</b>   |  |
| 24. FUNERAL DIRECTOR NAME <b>Sterling Funeral Estate</b>  |  |  |   |  | 25. DATE REC'D. BY REGISTRAR <b>MAR 1 1982</b>   |  |  |   |  |
| ADDRESS <b>736 Edmondson Ave. Catonsville, Md. 21228</b>  |  |  |   |  |  |  |  |   |  |

MEDICAL CERTIFICATION





UNITED STATES DEPARTMENT OF AGRICULTURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death and may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  | REG. NO. 8 2 0 4 3 0 0   |  |  |  |
|--|--|---|--|--|--|--|--|
| 1. FOR STATE REGISTRAR   |  |   |  |  |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT) <b>Helen F. Walsnovich</b>  |  |   |  | 2a. DATE OF DEATH MONTH <b>2</b> DAY <b>24</b> YEAR <b>82</b>  |  | 2b. HOUR <b>M</b>  |  |
| 3 SEX <b>Female</b>  |  | 4 RACE <b>White</b>   |  | 5. DATE OF BIRTH MONTH <b>Jan.</b> DAY <b>18</b> YEAR <b>1924</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY) <b>58</b> YRS                            |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>  |  | 7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.           |  |
| 10. CITY OR TOWN OF DEATH <b>Baltimore</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>3501 Parkside Drive</b> |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY <b>--</b>                              |  |
| 13a. STATE <b>Maryland</b>   |  | 13b. COUNTY <b>Baltimore</b>  |  | 13c. CITY OR TOWN <b>Baltimore</b>   |  | 13d. STREET ADDRESS <b>3501 Parkside Drive</b>                           |  |
| 14. FATHER'S NAME FIRST <b>Hillary</b> MIDDLE <b>Wilt</b> LAST <b>Wilt</b>   |  | 15. MOTHER'S MAIDEN NAME FIRST <b>Wilt</b> MIDDLE <b>Wilt</b> LAST <b>Wilt</b>  |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>  |  | 16b. SOCIAL SECURITY NO. <b>219-18-5896</b>   |  | 17. INFORMANT ADDRESS <b>Theodore Walsnovich 3501 Parkside Drive</b>   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Prob. C. Embolism</b><br><b>4100</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>S/P. Mitral v. Prosthesis, S/P Cor. bypass op.</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>Severe Ph. Mitral v. dis., Severe coro. art. dis.</b> |  |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                             |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)  |  |   |  |  |  |  |  |
| 19a. DATE OF OPERATION <b>June 1980</b>  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Severe Congestive Heart Failure as result of basic cardiac problem</b>        |  | 20a. AUTOPSY? <b>NO</b>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? <b>NO</b> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <b>NA</b>   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>NA</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) <b>NA</b>   |  |  |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> <b>NA</b>   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) <b>NA</b>   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>June 80 in Card. Clinic</b> to <b>Feb.</b> 19 <b>82</b> , that (I) (we) lost saw the deceased alive on <b>2/23/82</b> 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |   |  |  |  |  |  |
| 22b. SIGNATURE <b>A. Prempre</b> DEGREE <b>MD</b> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>   |  |   |  | 22c. DATE SIGNED <b>2/25/82</b>  |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>AMPORN PREMREE</b>  |  |   |  | 22e. ADDRESS <b>N-CHARLES GLEN HOSPITAL, CARDIAC CLINIC.</b>   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>  |  | 23b. DATE <b>3/1/82</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY <b>Meadowridge Mem. Park</b>  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore Howard Md.</b>      |  |
| 24. FUNERAL DIRECTOR NAME <b>A. Alan Seitz, Jr.</b> ADDRESS <b>Funeral Home 3818 Roland Ave.</b>   |  |   |  | 25a. DATE REC'D. BY REGISTRAR <b>FFR 26 1982</b>   |  | 25b. REGISTRAR'S SIGNATURE <b>James Van Natten</b>                       |  |

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TO HOSPITALS ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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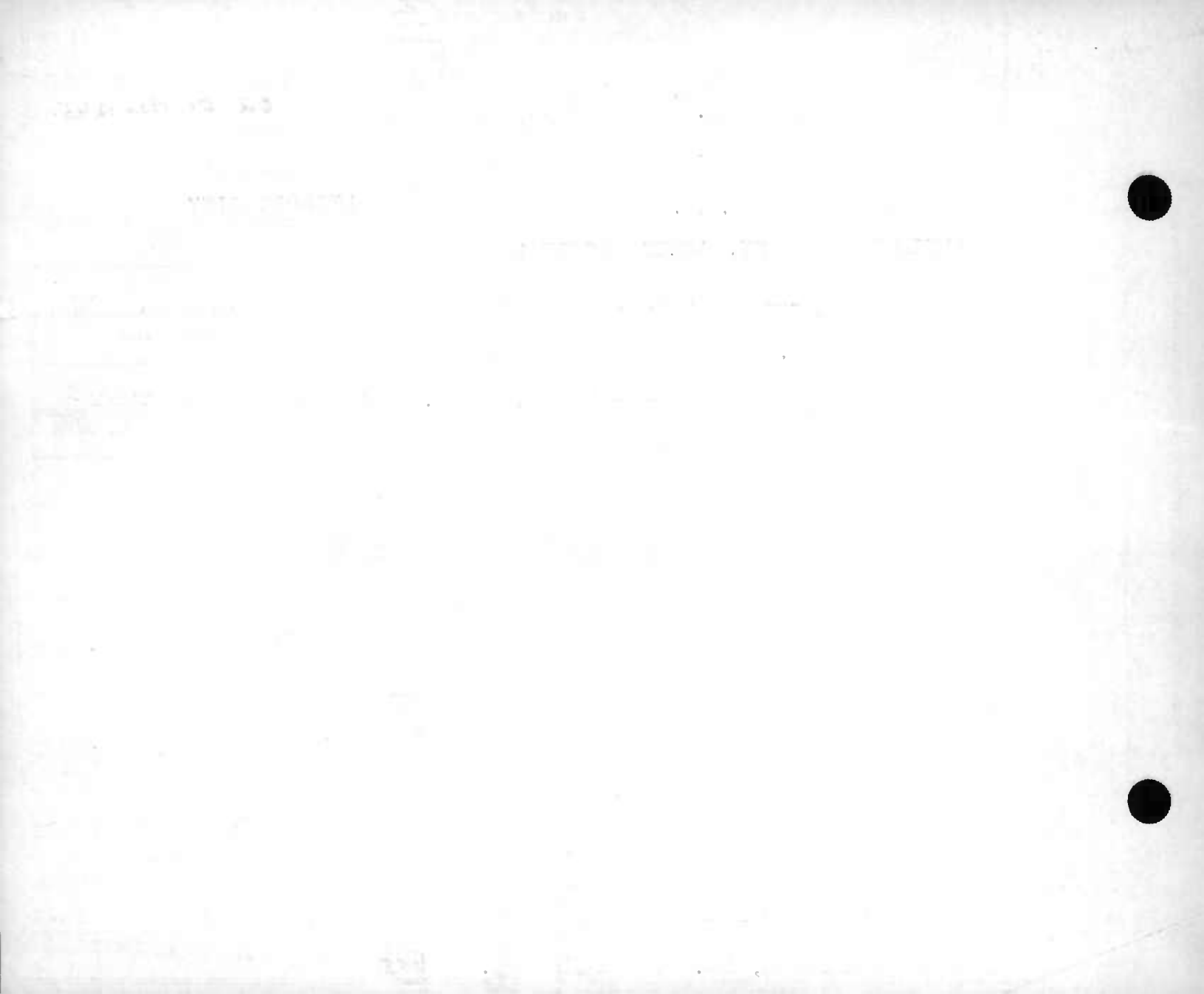
1- FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 4 3 0 1

REG. NO.

|   |  |  |  |  |  |  |   |  |   |   |  |
|---|--|--|--|--|--|--|---|--|---|---|--|
| 1 DECEASED NAME<br>(TYPE OR PRINT)<br>STEPHEN B. WALTER   |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>02 01 1982                      |  |  | 2b. HOUR<br>12:45 AM   |   |  |   |   |  |
| 3 SEX<br>MALE   |  | 4 RACE<br>WHITE  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>02 25 65   |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br>16 YRS   |   | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN  |   |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MARYLAND   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.                            |   |  |   |   |  |
| 10 CITY OR TOWN OF DEATH<br>BALTIMORE   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NO IN SUCH FACILITY, GIVE STREET ADDRESS)<br>ST. AGNES HOSPITAL |  |  |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>STUDENT          |   | 12b. KIND OF BUSINESS OR INDUSTRY<br>N/A   |   |   |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>MARYLAND  |  |  | 13b. COUNTY<br>---   |  | 13c. CITY OR TOWN<br>BALTIMORE                                   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br>2104 WILHELM STREET, 21223 |   |  |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br>WILLIAM V. WALTER  |  |  | 15 MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>HELEN WEIL             |  |  |  |   |  |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>NO  |  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>213-88-2145 |  | 17 INFORMANT<br>ADDRESS<br>WILLIAM V. WALTER 2104 WILHELM STREET |  |   |  |   |   |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>CARDIAC ARREST</u><br>3591<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:<br>(b) <u>Aspiration Pneumonia</u><br>(c) <u>MUSCULAR DYSTROPHY</u>         |  |  |  |  |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH      |   |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |  |  |  |  |  |   |  |   |   |  |
| 19a. DATE OF OPERATION  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |   |  |   |   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |   |  |   |   |  |
| 22a. I certify that (1) (this hospital) attended the deceased from <u>1/14/1982</u> to <u>2/1/1982</u> , that (1) (we) lost saw the deceased alive on <u>1/31/1982</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) did (did not) view the body after death. (AT 11:30 PM) |  |  |  |  |  |  |   |  |   |   |  |
| 22b. SIGNATURE<br><u>A. J. Dhillon</u><br>DEGREE<br>MD  |  |  |  |  |  | 22c. DATE SIGNED<br>2/1/82   |   |  |   |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>A.P.S. DHILLON   |  |  |  |  |  | 22e. ADDRESS<br>Saint Agnes Hospital, Baltimore, Md, 21225                           |   |  |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>BURIAL   |  |  | 23b. DATE<br>02-05-82  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>LORRAINE PARK              |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>WOODLAWN BALTIMORE MARYLAND                       |  |   |   |  |
| 24 FUNERAL DIRECTOR<br>NAME<br>HUBBARD FUNERAL HOME, INC.   |  |  |  |  |  | ADDRESS<br>4107 WILKENS AVE.   |   | 25a. DATE REC'D. BY REGISTRAR<br>FEB 3 1982  |   | 25b. REGISTRAR'S SIGNATURE<br><u>James J. [Signature]</u> |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrars, page 3 should be detached for use as the burial transit permit. Then please remove carbonpapers, Pages 1 and 2 should be filed with the registrar after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the attending physician should be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  |   |  |   |   |  |  | REG. NO. 8 2 0 4 3 0 2   |  |
|--|--|---|--|---|--|---|---|--|--|--|--|
| 1. FOR STATE REGISTRAR   |  |   |  |   |  |   |   |  |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>AGNES</b> FIRST <b>Agnes</b> MIDDLE <b>M.</b> LAST <b>Walters</b>   |  |   |  |   | 2a. DATE OF DEATH MONTH <b>2</b> DAY <b>3</b> YEAR <b>82</b> HOUR <b>7</b> MIN. <b>0</b>   |   |   |  |  |  |  |
| 3. SEX<br><b>Female</b>  |  | 4. RACE<br><b>White</b>   |  | 5. DATE OF BIRTH MONTH <b>10</b> DAY <b>1</b> YEAR <b>97</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>84</b> YRS.   |   | IF UNDER 1 YEAR MONTHS DAYS  |  | IF UNDER 24 HRS. HOURS MIN.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTO CITY</b> Balt. City                            |   |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTO CITY</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>ST. AGNES HOSP.</b> St. Agnes Hosp. |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Housewife</b>            |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Own Home</b>   |  |  |  |
| 13a. STATE<br><b>Maryland</b>  |  | 13b. COUNTY<br><b>Baltimore</b>   |  | 13c. CITY OR TOWN<br><b>Woodlawn</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 13e. STREET ADDRESS<br><b>1428 Langford Road</b>   |  |  |  |
| 14. FATHER'S NAME FIRST <b>John</b> MIDDLE <b>Bradunas</b> LAST <b>Bradunas</b>  |  |   |  |   | 15. MOTHER'S MAIDEN NAME FIRST <b>Anna</b> MIDDLE <b>Chymkus</b> LAST <b>Chymkus</b>   |   |   |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>No</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>220-82-7330</b>  |  | 17. INFORMANT<br><b>Donald J. Walters</b>   |  | ADDRESS<br><b>521 Forest Lane<br/>Baltimore, Md. 21228</b>                                      |   |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>4100 Cardio Respiratory arrest second to Deep Com.</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>Acute Chag. Infarction &amp; Cardiac arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>Arteriosclerotic Cardio Vascular Disease</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last |  |   |  |   |  |   |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>11 Days</b><br><b>11 Days</b><br><b>Unknown</b> |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |   |  |   |  |   |   |  |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |   |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |   |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>1/23/82</b> to <b>2/3/82</b> , that (I) (we) last saw the deceased alive on <b>2/2/82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |   |  |   |  |   |   |  |  |  |  |
| 22b. SIGNATURE<br><b>Cliff Ratliff, Jr.</b>  |  |   |  |   | DEGREE<br><b>M.D.</b> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   |   |  |  | 22c. DATE SIGNED<br><b>2/3/82</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>CLIFF RATLIFF, JR.</b>   |  |   |  |   | 22e. ADDRESS<br><b>5712 Westview Mall 21225</b>  |   |   |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>2/5/82</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Loudon Park Cemetery</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Md.</b>                              |   |  |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME <b>Witzke P.A.</b> ADDRESS<br><b>1630 Edmondson Avenue, Catonsville, Md. 21228</b>  |  |   |  |   | 25a. DATE REC'D. BY REGISTRAR<br><b>FEB 3 1982</b>   |   | 25b. REGISTRAR'S SIGNATURE<br><b>Thane J. [Signature]</b> |  |  |  |  |

ORIGINAL FILED

RECEIVED

FEB 7 1964



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  | REG. NO. 8 2 0 4 3 0 3   |  |   |  |
|---|--|---|--|--|--|---|--|
| 1. FOR STATE REGISTRAR  |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR 2b. HOUR  |  |   |  |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Margaret B. Walters  |  |   |  | Feb. 23, 1982 6 25 PM  |  |   |  |
| 3. SEX Female   |  | 4. RACE White   |  | 5. DATE OF BIRTH MONTH DAY YEAR March 18, 1894   |  | 6. AGE (IN YEARS LAST BIRTHDAY) 87 YRS. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.                         |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia  |  | 7b. CITIZEN OF WHAT COUNTRY? U.S.A.   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.   |  |
| 10. CITY OR TOWN OF DEATH Baltimore   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 4414 St. Thomas Ave. |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife  |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| 13a. STATE Maryland   |  |   |  | 13b. COUNTY  |  | 13c. CITY OR TOWN Baltimore   |  |
| 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |   |  | 13e. STREET ADDRESS 4414 St. Thomas Ave.   |  |   |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST Moses Lee Beckleheimer  |  |   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Corlida Spencer   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No  |  | 16b. SOCIAL SECURITY NO. 220-03-6867  |  | 17. INFORMANT ADDRESS Eunice Slack 4414 St. Thomas Ave.  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Dehydration<br>2500 DUE TO, OR AS A CONSEQUENCE OF<br>(b) Diabetes<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |   |  |  |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)  |  |   |  |  |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)   |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |   |  |
| 22a. I certify that (I) (the hospital) attended the deceased from 19 81, to Feb 23, 19 82, that (I) (we) lost saw the deceased alive on Feb 19 82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.   |  |   |  |  |  |   |  |
| 22b. SIGNATURE John H. Bowe MD  |  |   |  | DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>        |  | 22c. DATE SIGNED 2/23/82  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) John Bowe, M.D.   |  |   |  | 22e. ADDRESS 720 S. Hanover Street Baltimore, Maryland   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial  |  | 23b. DATE Feb. 26, 1982   |  | 23c. NAME OF CEMETERY OR CREMATORY Lorraine Park   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland  |  |
| 24. FUNERAL DIRECTOR NAME ADDRESS Leonard J. Ruck, Inc. Baltimore, Maryland   |  |   |  | 25a. DATE REC'D. BY REGISTRAR FEB 24 1982  |  | 25b. REGISTRAR'S SIGNATURE  |  |

1918

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 4 3 0 4

1- FOR  
STATE  
REGISTRAR

REG. NO.

|  |  |  |  |   |  |  |  |   |  |  |
|--|--|--|--|---|--|--|--|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>MARION L. WALTON</b>  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR <b>2 13 82</b>                                |   |  | 2b. HOUR <b>3 45</b> AM  |  |   |  |  |
| 3 SEX <b>Female</b>  |  | 4 RACE <b>White</b>  |  | 5. DATE OF BIRTH MONTH DAY YEAR <b>4 5 18</b>   |  | 6 AGE (IN YEARS LAST BIRTHDAY) <b>63</b> YRS   |  | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>md</b>  |  | 7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>  |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH <b>Balt. City</b> MD   |  |   |  |  |
| 10 CITY OR TOWN OF DEATH <b>S. Balt.</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>South Balt. Gen. Hosp.</b> |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>unemployed</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY <b>waitress</b>   |  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE <b>md</b>   |  |  | 13b. COUNTY  |   | 13c. CITY OR TOWN <b>Balt.</b>                                 |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   | 13e. STREET ADDRESS <b>1747 Belt St.</b>         |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST <b>John Adams</b>  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Emma Green</b>                   |   |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>  |  |   |  |  |
| 16b. SOCIAL SECURITY NO <b>215-76-4710</b>   |  |  | 17 INFORMANT <b>Chart, Faith A. Poland, Dr.</b>                                |   |  | ADDRESS <b>Severn, Md. 21144 Jamestown</b>   |  |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br><b>5609</b> IMMEDIATE CAUSE (a) <b>Cardio respiratory arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>Sepsis intraabdominal</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>Intestinal obstruction</b><br>CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), stating the underlying cause last. |  |  |  |   |  |  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH     |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>Intestinal obstruction</b>   |  |  |  |   |  |  |  |   |  |  |
| 19a. DATE OF OPERATION <b>2/12/82</b>  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Intestinal obstruction</b> |   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b> P.M.                    |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |   |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK   |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)            |   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>1/19</b> 19 <b>82</b> to <b>1/13</b> 19 <b>82</b> that (I) (we) last saw the deceased alive on <b>1/13</b> 19 <b>82</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |  |  |   |  |  |  |   |  |  |
| 22b. SIGNATURE <b>A. Zander</b>  |  |  | DEGREE   |   |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED <b>2/13/82</b>   |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>S. ZAMUDIO</b>  |  |  | 22e. ADDRESS <b>300 S. Hanover ST. Balt. MD</b>                                |   |  |  |  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>  |  |  | 23b. DATE <b>Feb. 16, 1982</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY <b>Loudon Park Cemetery</b> |  | 23d. LOCATION CITY OR TOWN COUNTY <b>Baltimore, Maryland</b>                                 |   | 23e. DATE REC'D. BY REGISTRAR <b>FEB 16 1982</b> |  |
| 24. FUNERAL DIRECTOR <b>McCurly Funeral Home, 130 E. Fort Ave. Balto. Md.</b>  |  |  | 25a. DATE REC'D. BY REGISTRAR <b>FEB 16 1982</b>                               |   |  | 25b. REGISTRAR'S SIGNATURE <b>Thomas J. Jantzen</b>  |  |   |  |  |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It must be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. The first part of the report is a general  
 description of the area. It is a large  
 area of land, mostly flat, with some  
 hills in the north. The climate is  
 temperate, with a lot of rain in the  
 winter and a lot of sun in the summer.  
 The soil is mostly clay, which is good  
 for growing crops. There are a few  
 rivers and streams in the area, and  
 some small lakes. The population is  
 about 100,000 people, and the  
 economy is mostly based on farming.  
 There are a few factories and  
 businesses, but most of the people  
 work in agriculture.

2. The second part of the report is a  
 description of the land. It is a large  
 area of land, mostly flat, with some  
 hills in the north. The climate is  
 temperate, with a lot of rain in the  
 winter and a lot of sun in the summer.  
 The soil is mostly clay, which is good  
 for growing crops. There are a few  
 rivers and streams in the area, and  
 some small lakes. The population is  
 about 100,000 people, and the  
 economy is mostly based on farming.  
 There are a few factories and  
 businesses, but most of the people  
 work in agriculture.

3. The third part of the report is a  
 description of the people. They are a  
 mix of different ethnicities, and most  
 of them speak the same language.  
 They are mostly farmers, but there  
 are also some workers and  
 businesspeople. They are a friendly  
 people, and they like to help each  
 other. They are a hardworking  
 people, and they are proud of their  
 land.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 50M 7/77  
(VR A 15 (4))

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 4 3 0 5

1 - FOR  
STATE  
REGISTRAR

REG. NO.

|   |  |   |   |  |  |  |  |  |
|---|--|---|---|--|--|--|--|--|
| 1 DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>GWENDOLYN ELIZABETH WARD   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>2 27 82                        |  |  | 2b. HOUR<br>7:10 M   |  |  |
| 3 SEX<br>female   |  | 4 RACE<br>Caucasian   |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>9 11 11  |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br>70 YRS                           |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>FLORIDA  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |   | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.         |  |  |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>BALTIMORE CITY HOSPITALS |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>HOMEMAKER        |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13a. STATE<br>MARYLAND  |  |   | 13b. COUNTY<br>BALTO.   |  | 13c. CITY OR TOWN<br>DUNDALK   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                            |  |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br>GROVER LEROY YELVINGTON  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>ADA LAVINA NASWORTHY |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>NO  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>578.42.0619  |   | 17. INFORMANT<br>ADDRESS<br>HAROLD LYON (SON-IN-LAW)   |  |  |  |  |
| 18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Respiratory Arrest</u><br>1809 DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cervical Ca Stage IV B</u><br>DUE TO, OR AS A CONSEQUENCE OF (c) |  |   |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |   |   |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>2/22</u> 19 <u>82</u> , to <u>2/23</u> 19 <u>82</u> , that (I) (we) lost<br>saw the deceased alive on <u>2/23</u> 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.      |  |   |   |  |  |  |  |  |
| 22b. SIGNATURE<br><u>Lawrence J. Appel</u>  |  |   |   | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>       |  | 22c. DATE SIGNED<br>2/23/82  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Lawrence J. Appel  |  |   |   | 22e. ADDRESS<br>Baltimore City Hospital  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>BURIAL  |  | 23b. DATE<br>2/26/1982  |   | 23c. NAME OF CEMETERY OR CREMATORY<br>CENTRAL METH. CEMETERY   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>LIBERTYTOWN MARYLAND |  |  |
| 24. FUNERAL DIRECTOR<br>WALTER BROOKS BRADLEY INC., DUNDALK MD 21222  |  |   |   | 25a. DATE REC'D. BY REGISTRAR<br>FEB 25 1982   |  | 25b. REGISTRAR'S SIGNATURE<br>Francis J. Nathan                    |  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 4 3 0 6

REG. NO.

|   |   |  |  |   |   |
|---|---|--|--|---|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>James O. Ward, Sr.</b>  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>FEB. 26 '82</b>  |  | 2b. HOUR<br><b>10 15 P. M.</b>  |   |
| 3. SEX<br><b>Male</b>   | 4. RACE<br><b>White</b>   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>May 30, 1913</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>68</b>  |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b>   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>                    |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.                               |   |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>UNION MEMORIAL HOSPITAL</b> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Carpenter</b> |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>James Keelty Co</b> |
| 13a. STATE<br><b>Maryland</b>   |   | 13b. COUNTY<br><b>Baltimore</b>  | 13c. CITY OR TOWN<br><b>Cockeysville</b>   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Charles Francis Ward</b>   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Ethel DeDavona Hedrick</b>   |  |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>XXXX NO</b>  |   | 16b. SOCIAL SECURITY NO.<br><b>214-03-0200</b>   |  | 17. INFORMANT<br>ADDRESS<br><b>Vandetta M. Ward, Same As #13c</b>                               |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>UPPER GI HEMORRHAGE - UNCONTROLLED.</b><br><b>2023</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>PROBABLE Histiocytic MEDULLARY RETICULOSIS</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. |   |  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____  |   |  |  |   |   |
| 19a. DATE OF OPERATION  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       |   |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |   |  |  |   |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                  |   |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>FEB. 18</b> , 19 <b>82</b> , to <b>FEB. 26</b> , 19 <b>82</b> , that (I) (we) last saw the deceased alive on <b>FEB. 26</b> , 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |   |  |  |   |   |
| 22b. SIGNATURE<br><b>I. Kelly-Dokubo M.D.</b>   |   | DEGREE<br><b>M.D.</b><br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br><b>FEB. 26, 1982</b>  |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>I. KELLY-DOKUBO M.D.</b>  |   | 22e. ADDRESS<br><b>UNION MEMORIAL HOSPITAL</b>   |  |   |   |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |   | 23b. DATE<br><b>3-2-82</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Dulaney Valley Mem.</b>                                |   |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Cockeysville, Balto. Maryland</b>  |   |  |  |   |   |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Ruck Towson Funeral Home, Inc. 1050 York Rd. Towson, Md. 21204</b>   |   | 25a. DATE REC'D. BY REGISTRAR<br><b>MAR 1 1982</b>   |  |   |   |
|   |   | 25b. REGISTRAR'S SIGNATURE<br><b>James Van Natten</b>  |  |   |   |



7-11-68

WARD

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  | REG. NO. 82 04307   |  |  |  |
|--|--|--|--|---|--|--|--|
| 1. FOR STATE REGISTRAR   |  |  |  | 2a. DATE OF DEATH   |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br>JEROME CLAUDE WARD   |  |  |  | MONTH DAY YEAR<br>2 12 82   |  |  |  |
| 3. SEX<br>MALE   |  |  |  | 7b. HOUR<br>11:50 PM  |  |  |  |
| 4. RACE<br>BLACK   |  |  |  | 7a. AGE (IN YEARS LAST BIRTHDAY)<br>72  |  |  |  |
| 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>7 10 09  |  |  |  | IF UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 24 HRS. HOURS MIN.  |  |  |  |
| 6. BIRTHPLACE (STATE OR FOREIGN)<br>WASHINGTON, MD   |  |  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  |  |
| 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  |  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE, CITY MD  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE   |  |  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>VAMC, 3900 LOCH RAVEN BLVD.                       |  |  |  |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |  |  |
| 13a. STATE<br>MARYLAND   |  |  |  | 13b. COUNTY   |  |  |  |
| 13c. CITY OR TOWN<br>Baltimore   |  |  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |  |  |
| 13e. STREET ADDRESS<br>11 W. 20th St.  |  |  |  | 14. FATHER'S NAME FIRST MIDDLE LAST<br>Nathan Ward  |  |  |  |
| 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Martha Washington  |  |  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES NO OR UNKNOWN)<br>YES   |  |  |  |
| 16b. SOCIAL SECURITY NO.<br>WWI  |  |  |  | 17. INFORMANT ADDRESS<br>Pamula Griffin 755 Lennox St.  |  |  |  |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Diffuse Carcinomatosis (1539)<br>DUE TO, OR AS A CONSEQUENCE OF (b) Colon Cancer (IV)<br>DUE TO, OR AS A CONSEQUENCE OF (c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>1 1/2 months |  |  |  | PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a                          |  |  |  |
| 19a. DATE OF OPERATION<br>2/2/82   |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br>GASTRIC Outlet Obstruction  |  |  |  |
| 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                  |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)  |  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  |  |  |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)<br>N/A  |  |  |  | 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |  |  |
| 21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)   |  |  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a. I certify that (X) (this hospital) attended the deceased from 1-26, 19-82, to 2-12, 19-82, that (XX) (we) last saw the deceased alive on 2-12, 19-82, and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) (did) (not) view the body after death.             |  |  |  | 22b. SIGNATURE<br>T. FULBRIGHT  |  |  |  |
| 22c. PHYSICIAN'S NAME (TYPE OR PRINT)<br>T. FULBRIGHT  |  |  |  | 22d. ADDRESS<br>3900 Loch Raven Blvd. BALTO. Md. 21218  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial  |  |  |  | 23b. DATE<br>2/18/82  |  |  |  |
| 23c. NAME OF CEMETERY OR CREMATORY<br>Baltimore Nat'l  |  |  |  | 23d. LOCATION<br>Baltimore MD   |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Wm. C. March F/H   |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br>FEB 16 1982  |  |  |  |
| 25b. REGISTRAR'S SIGNATURE<br>Ann Jan Math   |  |  |  | 25c. ADDRESS<br>1101 E. North Ave.  |  |  |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |  | 8 2 0 4 3 0 8<br>REG. NO.                            |  |  |   |  |
|--|--|--|--|--|--|--|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>MARTIN R. WARD  |  |  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>FEBRUARY 9, 1982 |  |  | 2b. HOUR<br>M   |  |
| 3. SEX<br>MALE   |  | 4. RACE<br>WHITE   |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>OCT 22, 1905  |  | 6. AGE (IN YEARS (LAST BIRTHDAY))<br>76 YRS.   |  | 7. IF UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 24 HRS. HOURS MIN.   |  |
| 8. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MARYLAND   |  | 9. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  | 10. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.                                   |  |   |  |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>5419 PIMBROKE AVE. |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>SHIPPER                     |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>MORGAN MILL  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE<br>MD.  |  | 13b. COUNTY  |  | 13c. CITY OR TOWN<br>BALTIMORE   |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br>5419 PIMBROKE AVE.   |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>GEORGE WARD   |  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>AMANDA OREM  |  |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>NO  |  |  |  | 16b. SOCIAL SECURITY NO<br>215 03 1674   |  | 17. INFORMANT ADDRESS<br>FAMILY RECORDS  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) 4100 Acute myocardial infarction<br>DUE TO, OR AS A CONSEQUENCE OF (b) Coronary Arteriosclerotic Cardiovascular Disease<br>DUE TO, OR AS A CONSEQUENCE OF (c)<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |  |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>minutes<br>2 years  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a.<br>Chronic Obstructive Pulmonary Disease   |  |  |  |  |  |  |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>                       |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)   |  |  |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from OCT 22, 19 81, to NOV 11, 19 81, that (I) (we) last saw the deceased alive on NOV 11, 19 81, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.  |  |  |  |  |  |  |  |   |  |
| 22b. SIGNATURE<br>Walter R. Wellant, M.D.  |  |  |  | DEGREE<br>M.D.   |  |  |  | 22c. DATE SIGNED<br>17 FEB 1982   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>WALTER R. WELLANT   |  |  |  | 22e. ADDRESS<br>MEDICAL ARTS BLDG.   |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>BURIAL  |  | 23b. DATE<br>2-16-1982   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>LODON PARK   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>BALTIMORE Maryland                                |  |   |  |
| 24. FUNERAL DIRECTOR NAME<br>EVANS FUNERAL CHAPEL  |  |  |  | ADDRESS<br>8800 HARFORD RD.  |  | 25. DATE RECEIVED BY REGISTRAR<br>FEB 22 1982  |  | 26. REGISTRAR'S SIGNATURE<br>James J. [Signature]   |  |



RECEIVED  
NOTES

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 4 3 0 9

REG. NO.

|   |  |  |   |  |                                   |  |  |
|---|--|--|---|--|-----------------------------------|--|--|
| FOR<br>1 - STATE<br>REGISTRAR   |  | 1. DECEASED NAME<br>(TYPE OR PRINT)  |   | 2a. DATE OF DEATH  |                                   | 2b. HOUR   |  |
| ROSS  |  | WARD   |   | FEBRUARY 20, 1982  |                                   | 11:53a M   |  |
| 3. SEX  | 4. RACE  | 5. DATE OF BIRTH   |   | 6. AGE (IN YEARS LAST BIRTHDAY)  |                                   | 7. IF UNDER 1 YEAR   |  |
| MALE  | CAU.   | 11 15 1901   |   | 80   |                                   | MONTHS DAYS HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   | 7b. CITIZEN OF WHAT COUNTRY?   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH   |                                   |  |  |
| MARYLAND  | U.S.A.   |  |   | Baltimore City   |                                   | MD.  |  |
| 10. CITY OR TOWN OF DEATH   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) |  | 12b. KIND OF BUSINESS OR INDUSTRY |  |  |
| Baltimore   | Maryland General Hospital  |  | Oil Business  |  | Home                              |  |  |
| 13a. STATE  |  | 13b. COUNTY  | 13c. CITY OR TOWN   | 13d. INSIDE CITY LIMITS?   | 13e. STREET ADDRESS               |  |  |
| md  |  |  | BALTA   | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  | 2211 West Rodgers Ave             |  |  |
| 14. FATHER'S NAME   |  | 15. MOTHER'S MAIDEN NAME   |   |  |                                   |  |  |
| Randolph  |  | Laura Davis  |   |  |                                   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)   |  | 16b. SOCIAL SECURITY NO.   |   | 17. INFORMANT ADDRESS  |                                   |  |  |
| No  |  | 213-074656A  |   | Alice Ward 2211 West Rodgers Ave   |                                   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |  |  |   |  |                                   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) CVA   |  |  |   |  |                                   |  | 9 days                                       |
| 4149<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.  |  |  |   |  |                                   |  | 9 days                                       |
| DUE TO, OR AS A CONSEQUENCE OF (b) Brain Herniation   |  |  |   |  |                                   |  |  |
| DUE TO, OR AS A CONSEQUENCE OF (c) Atrial Fibrillation  |  |  |   |  |                                   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |  |   |  |                                   |  |  |
| Coronary Artery Disease   |  |  |   |  |                                   |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   | 20a. AUTOPSY?  |                                   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |  |
|   |  |  |   | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                                   | YES <input type="checkbox"/> NO <input type="checkbox"/>       |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)   |                                   |  |  |
|   |  |  |   |  |                                   |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |                                   |  |  |
|   |  |  |   |  |                                   |  |  |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from February 11, 19 82, to February 20, 19 82, that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on February 20, 19 82, and that <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) did not view the body after death. |  |  |   |  |                                   |  |  |
| 22b. SIGNATURE  |  |  |   | DEGREE   |                                   | 22c. DATE SIGNED   |  |
| JUDITH VEIHMEYER, M.D.  |  |  |   | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |                                   | 2/20/82  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  |  |   | 22e. ADDRESS   |                                   |  |  |
|   |  |  |   | c/o MARYLAND GENERAL HOSPITAL  |                                   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |  | 23b. DATE  |   | 23c. NAME OF CEMETERY OR CREMATORY   |                                   | 23d. LOCATION CITY OR TOWN COUNTY STATE                        |  |
| CREMATION   |  |  |   | WESTVIEW MEMORIAL PARK   |                                   | BALTO MD   |  |
| 24. FUNERAL DIRECTOR NAME ADDRESS   |  |  |   | 25a. DATE REC'D. BY REGISTRAR  |                                   | 25b. REGISTRAR'S SIGNATURE                                     |  |
| BURGEE FUNERAL HOME 3631 FALLS RD 21211   |  |  |   | FEB 25 1982  |                                   | R. J. Math   |  |

11-1-55

FEBRUARY 20, 1955

1955

10

1955

Baltimore City

U.S.

1955

Harvard General Hospital

1955

1955

1955

Brain necrosis

Atrial fibrillation

Coronary Artery Disease

February 17, 1955

February 20, 1955

Dr. HARRY H. GENERAL HOSPITAL

JOSEPH V. VEINSTEIN, M.D.

1955

1955

1955



Items 3, 6, 8566 4/21/82 fj

STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 4 3 1 0

FOR  
1 - STATE  
REGISTRAR

REG. NO.

|  |  |  |  |  |   |                                   |
|--|--|--|--|--|---|-----------------------------------|
| 1 DECEASED NAME<br>(TYPE OR PRINT)   |  | FIRST<br><i>Pearl</i>  | MIDDLE   | LAST<br><i>WARNEKOW</i>  | 2a DATE OF DEATH<br>MONTH DAY YEAR<br><i>2/21/82</i>  | 2b HOUR<br><i>730 P.M.</i>        |
| 3 SEX<br><i>FEMALE</i>   | 4 RACE<br><i>white</i>   | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br><i>07-06-1895</i>   |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br><i>86</i> YRS  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.   |                                   |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><i>Russia</i>  | 7b CITIZEN OF WHAT COUNTRY?<br><i>USA</i>  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><i>Balt. city</i> MD.   |   |                                   |
| 10 CITY OR TOWN OF DEATH<br><i>Baltimore</i>   | 11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><i>Levinthal Ger. Ctr. Hosp.</i> |  |  | 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><i>HOUSEWIFE</i>  | 12b KIND OF BUSINESS OR INDUSTRY<br><i>AT HOME</i>  |                                   |
| 13a STATE<br><i>MARYLAND</i>   | 13b COUNTY<br><i>BALTO.</i>  | 13c CITY OR TOWN<br><i>OWINGS MILLS</i>  | 13d INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e STREET ADDRESS<br><i>APT. 4<br/>14 Bitterroot Ct.<br/>#21117</i>   |   |                                   |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br><i>UNKNOWN ABRAHAM</i>  |  | 15 MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><i>UNKNOWN</i>   |  |  |   |                                   |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><i>NO</i>   |  | 16b SOCIAL SECURITY NO.<br><i>214-74-5591</i>  |  | 17 INFORMANT<br><i>MRS. ROSE GOODMAN</i><br><i>3401 TULSA RD. BALTO., MD 21207</i>   |   |                                   |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART 1: DEATH WAS CAUSED BY:<br><i>4442 PROBABLE Pulmonary Embolism</i><br>IMMEDIATE CAUSE (a) <i>4442</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <i>fatal emboli</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <i>ASCVD, peripheral vascular disease</i><br>PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <i>ASCVD, peripheral vascular disease</i><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><i>1 year</i> |  |  |  |  |   |                                   |
| MEDICAL CERTIFICATION  |  |  |  |  |   |                                   |
| 19a DATE OF OPERATION  |  | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                                   |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. <i>19</i>   |  | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |   |                                   |
| 21d INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |                                   |
| 22a I certify that (I) (this hospital) attended the deceased from <i>3/25</i> , 19 <i>81</i> , to <i>2/21</i> , 19 <i>82</i> , that (I) (we) lost<br>saw the deceased alive on <i>2/21</i> , 19 <i>82</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.  |  |  |  |  |   |                                   |
| 22b SIGNATURE<br><i>B. ZAW-WIN</i>   |  | DEGREE<br><i>MD.</i>   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   | 22c DATE SIGNED<br><i>2/21/82</i> |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)<br><i>B. ZAW-WIN</i>  |  | 22e ADDRESS<br><i>Levinthal Geriatric Center &amp; Hosp</i>  |  |  |   |                                   |
| 23a BURIAL, CREMATION, REMOVAL<br>(SPECIFY) <i>BURIAL</i>  |  | 23b DATE<br><i>FEB. 23, 1982</i>   | 23c NAME OF CEMETERY OR CREMATORY<br><i>BETH TFILOH</i>  |  | 23d LOCATION<br>CITY OR TOWN COUNTY STATE<br><i>BALTIMORE BALTO. MARYLAND</i>   |                                   |
| 24 FUNERAL DIRECTOR<br>NAME ADDRESS<br><i>SOL LEVINSON &amp; BROS., INC.<br/>6010 REISTERSTOWN RD. BALTO., MD 21215</i>  |  |  | 25a DATE REC'D. BY REGISTRAR<br><i>FEB 24 1982</i>   |  |   |                                   |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, and may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

• 1994 •

SHR. AS 674

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  | REG. NO. 82 04311   |  |   |  |
|--|--|--|--|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br><b>JAMES H WARREN</b>   |  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>FEBRUARY 9, 1982</b>   |  | 2b. HOUR<br><b>03:30a</b>   |  |
| 3. SEX<br><b>Male</b>  |  | 4. RACE<br><b>White</b>  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>June 5, 1910</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY) YRS.<br><b>71</b>   |  |
| 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Pennsylvania</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>JOHNS HOPKINS HOSPITAL</b> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Maintenance</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Retail Sales</b>  |  |
| 13a. STATE<br><b>Pennsylvania</b>  |  |  |  | 13b. COUNTY<br><b>York</b>  |  | 13c. CITY OR TOWN<br><b>Dover</b>   |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>John Warren</b>  |  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Gertrude LeFever</b>   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES OR NO OR UNKNOWN)<br><b>No</b>  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>188-03-9819</b>  |  | 17. INFORMANT ADDRESS<br><b>Mary Warren Dover, Pennsylvania</b>   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>cardiac arrest</b><br><b>2051</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>hypertension and metabolic acidosis</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>sepsis and acute renal failure</b><br>CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |  |  |   |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)<br><b>chronic myelogenous leukemia</b>   |  |  |  |   |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                      |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>2/9</b> , 19 <b>82</b> , to <b>2/9</b> , 19 <b>82</b> , that (I) (we) last saw the deceased alive on <b>2/9</b> , 19 <b>82</b> , and that (I) (we) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.  |  |  |  |   |  |   |  |
| 22b. SIGNATURE<br><b>Robert J. Garver, Jr.</b> MD  |  |  |  | 22c. DATE SIGNED<br><b>2/9/82</b>   |  | 22d. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  |
| 22e. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>ROBERT GARVER</b>  |  |  |  | 22f. ADDRESS<br><b>JOHNS HOPKINS HOSP<br/>DEPT. OF MED</b>  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>Feb. 12, '82</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Mount Rose Cemetery York Co., PA</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>William E. Johnson</b>  |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>FEB 10 1982</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><i>Thomas J. [Signature]</i>  |  |
| ADDRESS<br><b>8521 Loch Raven Blvd.</b>  |  |  |  |   |  |   |  |

—

[illegible]

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbonpapers, Pages 1 and 2 should be filed within 72 hours after death. Page 3 should be retained by the attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers, Pages 1 and 2 should be filed within 72 hours after death. Page 3 should be retained by the attending physician.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |   |  |  |                                       |  |   |  |
|--|--|--|--|---|--|--|---------------------------------------|--|---|--|
| 1. FOR STATE REGISTRAR   |  |  |  |   | REG. NO. 8204312   |  |                                       |  |   |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>THOMAS A. WASHINGTON</b>   |  |  |  |   | 2a. DATE OF DEATH<br>MONTH <b>02</b> DAY <b>13</b> YEAR <b>82</b><br>2b. HOUR <b>2:45</b> <b>A</b> |  |                                       |  |   |  |
| 3. SEX<br><b>Male</b>  |  | 4. RACE<br><b>Black</b>  |  | 5. DATE OF BIRTH<br>MONTH <b>2</b> DAY <b>25</b> YEAR <b>85</b>   |  | 6. AGE<br>(IN YEARS LAST BIRTHDAY)<br><b>02965</b> YRS.                                |                                       | 7. # UNDER 1 YEAR<br>MONTHS <b>02</b> DAYS <b>13</b>   |   |  |
| 7b. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br><b>West Indies</b>   |  | 7c. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.                      |                                       |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>JOHNS HOPKINS HOSPITAL</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)                       |                                       | 12b. KIND OF BUSINESS OR INDUSTRY  |   |  |
| 13a. STATE<br><b>MD</b>  |  |  |  |   | 13b. COUNTY  |  | 13c. CITY OR TOWN<br><b>Baltimore</b> |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 14. FATHER'S NAME<br>FIRST <b>James</b> MIDDLE <b>Washington</b> LAST <b>Washington</b>  |  |  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>Catherine</b> MIDDLE <b>Eager</b> LAST <b>St.</b>             |  |                                       |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>212-09-6651</b>  |  | 17. INFORMANT<br>ADDRESS<br><b>Louella Washington 2005 E. Eager St.</b>   |  |  |                                       |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Metastatic Prostatic Cancer</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>1850</b><br>(c) <b>1 yr.</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>DUE TO, OR AS A CONSEQUENCE OF<br>DUE TO, OR AS A CONSEQUENCE OF |  |  |  |   |  |  |                                       |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)   |  |  |  |   |  |  |                                       |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                                       | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR <b>19</b> MONTH <b>12</b> DAY <b>13</b> YEAR <b>82</b><br>P.M.   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |                                       |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>CITY OR TOWN <b>Baltimore</b> COUNTY <b>Baltimore</b> STATE <b>MD</b>  |  |  |                                       |  |   |  |
| 22a. I certify that (I) (the hospital) attended the deceased from <b>2/19</b> to <b>2/13</b> , 19 <b>82</b> , that (I) (we) last saw the deceased alive on <b>2/13</b> , 19 <b>82</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.  |  |  |  |   |  |  |                                       |  |   |  |
| 22b. SIGNATURE<br><b>Francine Welby</b>  |  |  |  | 22c. DATE SIGNED<br><b>2/13/82</b>  |  |  |                                       | 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Francine Welby</b>   |   |  |
| 22e. ADDRESS<br><b>Johns Hopkins Hospital</b>  |  |  |  | 22f. DATE REC'D. BY REGISTRAR<br><b>FEB 16 1982</b>   |  |  |                                       |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>2/18/82</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Baltimore Cemetery</b>   |  | 23d. LOCATION<br>CITY OR TOWN <b>Baltimore</b> COUNTY <b>Baltimore</b> STATE <b>MD</b> |                                       | 23e. REGISTRAR'S SIGNATURE<br><b>Thomas J. Smith</b>   |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Wm. C. March F/H</b>  |  |  |  | 24b. ADDRESS<br><b>1101 E. North Ave.</b>   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>FEB 16 1982</b>                                    |                                       |  |   |  |

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UNITED STATES

UNITED STATES DEPARTMENT OF AGRICULTURE

WASHINGTON, D.C.

FEB 18 1954



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 4 3 1 3

REG. NO.

|  |   |   |  |  |  |
|--|---|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>Legrand Watkins</b>   |   |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>2 20 82</b>                              |  | 2b. HOUR<br><b>7:30 A</b>  |
| 3. SEX<br><b>male</b>  | 4. RACE<br><b>Negroid</b>   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>4-1-08</b>   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>73</b> YRS                                   |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>South Carolina</b>   | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Balto. City</b> MD                      |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTO.</b>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Union Memorial Hospital</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Retired</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>Md.</b>   |   |   | 13b. COUNTY<br><b>—</b>  | 13c. CITY OR TOWN<br><b>BALTO</b>  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Cornelius Watkins</b>   |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Mary G. Corington</b>          |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>  |   | 16b. SOCIAL SECURITY NO.<br><b>N 216-10-1027AB</b>  | 17. INFORMANT<br>ADDRESS<br><b>Lamotte Hines 1102 Druid Hill St</b>                |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Pulmonary edema / CHF</b><br><b>5850</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>CHF</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>chronic renal failure.</b> |   |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)<br><b>gangrene @ INJURY from BR / glaucoma / anemia / PK / diabetes</b>   |   |   |  |  |  |
| 19a. DATE OF OPERATION   |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>2 21 82</b>   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)     |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |   | 21e. PLACE OF INJURY<br>(AT HOME-STREET, FACTORY, OFFICE, FARM, ETC.)   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>2/21</b> , 19 <b>82</b> , to <b>2/20</b> , 19 <b>82</b> , that (I) (we) last saw the deceased alive on <b>2/21</b> , 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If not, did not view the body after death.)  |   |   |  |  |  |
| 22b. SIGNATURE<br><b>Brian Nelson</b>  |   | DEGREE<br><b>MD</b>   |  | 22c. DATE SIGNED<br><b>2/20/82</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Brian Nelson MD</b>  |   | 22e. ADDRESS<br><b>Union Memorial Hosp 2416 Univ Pkwy BALTO MD</b>  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(TYPE IF)<br><b>Burial</b>  | 23b. DATE<br><b>2-25-82</b>   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Baltimore Cem.</b>   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Md.</b>                 |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Calvin B Scruggs</b>  |   | 25a. DATE REC'D. BY REGISTRAR<br><b>FEB 22 1982</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Frances Jean Wether</b>                             |  |



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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires a certificate of death to be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  | REG. NO. 8 2 0 4 3 1 4   |  |  |   |
|--|--|--|--|--|--|--|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>GRACE WATSON</b>  |  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR <b>2-20-82</b>   |  |  |   |
| 3. SEX <b>Fe.</b>  |  | 4. RACE <b>Black</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR <b>9 19 1920</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>61</b> YRS.  |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Columbus, NC</b>  |  | 7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>   |  | 8. <b>SEP.</b><br>MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.  |   |
| 10. CITY OR TOWN OF DEATH<br><b>BALTO</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br><b>THE JOHNS HOPKINS HOSPITAL</b> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Home.</b>  |   |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE <b>Md.</b> 13b. COUNTY <b>BALTO</b> 13c. CITY OR TOWN <b>BALTO</b>  |  |  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |  |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST <b>Thom Pringle</b>   |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST <b>Lula Flowers</b>  |  |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>No</b>   |  | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT ADDRESS<br><b>Elvora Watson 1020 N. Rosedale</b>   |  |  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARDIAL ELECTRO MECHANICAL DISSOCIATION</b><br><b>5860</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>SEVERE HYPOTENSION</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>OVERWHELMING UREMIA</b> |  |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>10 MINUTES</b> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:</b>  |  |  |  |  |  |  |   |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                       |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>2/17</b> , 19 <b>82</b> , to <b>2/20</b> , 19 <b>82</b> , that (I) (we) lost saw the deceased alive on <b>2/20</b> , 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |  |  |  |  |  |   |
| 22b. SIGNATURE<br><b>Vladimir Svesko</b> MD  |  |  |  | DEGREE<br><b>MD</b>  |  | 22c. DATE SIGNED<br><b>2/20/82</b>   |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>VLADIMIR SVESKO, M.D.</b>  |  |  |  | 22e. ADDRESS<br><b>JOHNS HOPKINS HOSPITAL</b>  |  |  |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY) <b>Burial</b>   |  | 23b. DATE<br><b>2/25/82</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Jenkins Cem.</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Whiteville N.C.</b>   |   |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>JAS. A. MORTON 1701 LAURENS</b>   |  |  |  | 25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE<br><b>FEB 22 1982 Frances Jean Nathan</b>   |  |  |   |

APR 1985

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J. S. Smith

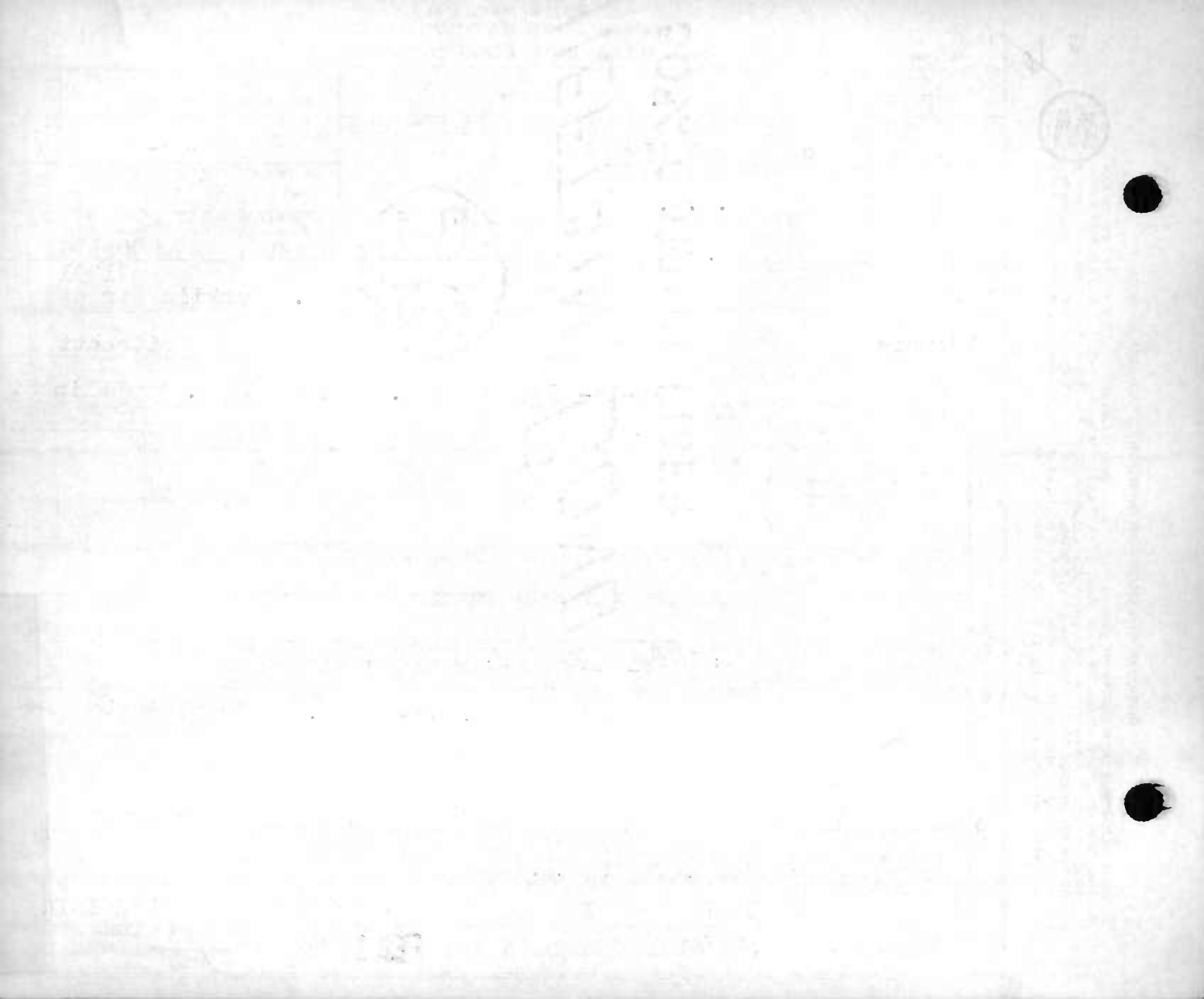
TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL HOME. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER. ALONG WITH PM 3, RETAIN PAGE 5 FOR YOUR FILES. IF THE DEATH IS SUSPECTED, PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER. TRANSIT PERMIT, PAGES 1 AND 2 SHOULD BE FILED, WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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(VR A15 ME (5))  
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## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |  |                         |   |   |                                       |   |   |  |   | REG. NO. 04315  |  |
|--|--|-------------------------|---|---|---------------------------------------|---|---|--|---|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>SUSIE (SUSAN) J. WATSON</b>   |  |                         |   |   |                                       |   | 2a. DATE KNOWN OF DEATH<br>MONTH DAY YEAR<br><b>2-11-82</b>                                     |  | 2b. HOUR<br>M<br><b>11:30</b>                                 |   |  |
| 3. SEX<br><b>female</b>  |  | 4. RACE<br><b>Negro</b> |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>DEC 2 1915</b>                       |                                       | 6. AGE (IN YEARS)<br>LAST BIRTHDAY YRS.<br><b>66</b>  |   | 7c. DATE PRONOUNCED DEAD<br>MONTH DAY YEAR<br><b>2-11-82</b> |   | 7d. HOUR<br>M<br><b>11:30</b>   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>VIRGINIA</b>   |  |                         | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |   |                                       | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |  |                         | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>618 W. Franklin Street</b> |   |                                       |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>BAKER</b>                   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>COLLEGE</b>           |   |  |
| 13a. STATE<br><b>MARYLAND</b>  |  |                         | 13b. COUNTY<br><b>BALTIMORE</b>   |   | 13c. CITY OR TOWN<br><b>BALTIMORE</b> |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>618 W. Franklin Street</b>          |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Leonard Cook</b>  |  |                         |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Ada Fitchett</b>          |                                       |   |   |  |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br><b>NO</b>   |  |                         |   | 16b. SOCIAL SECURITY NO.<br><b>216-14-7504</b>                                |                                       | 17. INFORMANT ADDRESS<br><b>Jesse A. Watson/618 W. Franklin St</b>  |   |  |   |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br><b>9530</b> IMMEDIATE CAUSE (a) <b>Hanging</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____  |  |                         |   |   |                                       |   |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).  |  |                         |   |   |                                       |   |   |  |   |   |  |
| 19a. DATE OF OPERATION   |  |                         |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                             |                                       |   |   |  |   | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |  |                         |   | 21b. TIME OF INJURY<br>HOUR MINUTE MONTH DAY YEAR<br><b>4:40 P.M. 2-11-82</b> |                                       | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)<br><b>subject hanged self</b>   |   |  |   |   |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>  |  |                         |   | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)<br><b>home</b>    |                                       | 21f. LOCATION<br>CITY OR TOWN STREET CITY OR COUNTY STATE<br><b>618 W. Franklin St. Baltimore, Maryland</b>   |   |  |   |   |  |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |                         |   |   |                                       |   |   |  |   |   |  |
| ACTUAL SIGNATURE<br><b>Margie A. Krell</b>   |  |                         |   | TITLE (SPECIFY)<br><b>Assistant</b>   |                                       |   |   | DATE<br><b>2-11-82</b>                                       |   |   |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)<br><b>Margarita A. Korell, M.D.</b>   |  |                         |   | ADDRESS<br><b>111 Penn Street</b>   |                                       |   |   |  |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>TRANSIT/BURIAL</b>  |  |                         |   | 23b. DATE<br><b>02/16/82</b>  |                                       | 23c. NAME OF CEMETERY OR CREMATORY<br><b>MT ZION BAPT CHURCH</b>  |   |  |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>MIDDLESEX CO VIRGINIA</b>          |  |
| 24. FUNERAL DIRECTOR<br><b>MARSHALL W JONES, JR.</b>   |  |                         |   |   |                                       | 25a. DATE REC'D. BY REGISTRAR<br><b>FEB 16 1982</b>   |   | 25b. REGISTRAR'S SIGNATURE<br><b>James J. [Signature]</b>    |   |   |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  |   |   |   |   |   |  |
|---|--|--|--|---|---|---|---|---|--|
| 1. FOR<br>STATE<br>REGISTRAR  |  | REG. NO. 8204316   |  |   |   |   |   |   |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>PETRONELA WAWRYKIW</b>   |  |  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>February 25, 1982</b>                                 |   |   | 2b. HOUR<br>M   |  |
| 3. SEX<br><b>Female</b>   |  | 4. RACE<br><b>White</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>June 16, 1902</b>  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>79</b> YRS.   |   | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Ukraine</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>Ukraine</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.   |   |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>2224 Essex St.</b> |  |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>House-wife</b>   |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Home</b>  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |  |  |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   |   |   |  |
| 13a. STATE<br><b>Maryland</b>   |  | 13b. COUNTY<br><b>- -</b>  |  | 13c. CITY OR TOWN<br><b>Baltimore</b>   |   | 13e. STREET ADDRESS<br><b>2224 Essex St.</b>  |   |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Maxim - Peresada</b>   |  |  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Eryne - Kizyma</b>                          |   |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>NO - -</b>   |  |  |  |   | 16b. SOCIAL SECURITY NO.<br><b>214-30-3100</b>  |   | 17. INFORMANT<br>ADDRESS<br><b>Teodoro Ewachiw 3110 O'Donnell St.</b>   |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br><b>4292 Acute CPA</b><br>IMMEDIATE CAUSE (a) <b>Admitted</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>Accident</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>years.</b>  |  |  |  |   |   |   |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br><b>days</b>  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>Respirator after hrs.</b>   |  |  |  |   |   |   |   |   |  |
| 19a. DATE OF OPERATION  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |   | 19c. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |   | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |   |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost<br>saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above. (I) (we) (did) (did not) view the body after death. |  |  |  |   |   |   |   |   |  |
| 22b. SIGNATURE<br><b>Gracito P. Patricio</b>  |  |  |  |   |   | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   | 22c. DATE SIGNED  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Dr. Gracito Patricio</b>  |  |  |  |   |   | 22e. ADDRESS<br><b>2926 E. Cold Spring Lane</b>   |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |  |  | 23b. DATE<br><b>March 1, 1982</b>                                      |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>St. Michael's Ukrainian</b>                            |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Maryland</b> |   |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Lilly &amp; Zeiler, Inc. 1901 Eastern Ave.</b>   |  |  |  |   |   | 25a. DATE REC'D. BY REGISTRAR<br><b>MAR 1 1982</b>  |   | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>  |  |





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 7 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and the medical certification completed.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  | REG. NO. 82 04317   |  |   |  |
|--|--|---|--|---|--|---|--|
| 1. FOR STATE REGISTRAR   |  |   |  | 2a. DATE OF DEATH   |  |   |  |
| 1. DECEASED NAME (TYPE OR PRINT) <b>George B. WAYS</b>   |  |   |  | 2b. DATE OF DEATH MONTH <b>2</b> DAY <b>8</b> YEAR <b>82</b> 2b HOUR <b>8:20</b> AM   |  |   |  |
| 3 SEX <b>Male</b>  |  | 4 RACE <b>White</b>   |  | 5. DATE OF BIRTH MONTH <b>MARCH</b> DAY <b>22</b> YEAR <b>1896</b>  |  | 6 AGE (IN YEARS LAST BIRTHDAY) <b>85</b> YRS  |  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Md.</b>  |  | 7b CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>   |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>   |  | 9 BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.   |  |
| 10. CITY OR TOWN OF DEATH <b>Baltimore</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (NOT IN WHICH CITY, GOVT STREET ADDRESS) <b>John L. Newton Medical Center</b> |  | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Mail CARRIER</b>  |  | 12b KIND OF BUSINESS OR INDUSTRY <b>Postal</b>  |  |
| 13a STATE <b>Md.</b>   |  | 13b CITY OR TOWN <b>Marietta</b>  |  | 13c STREET ADDRESS <b>Marietta Rcl.</b>   |  | 13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                             |  |
| 14 FATHER'S NAME FIRST <b>HARRY</b> MIDDLE <b>WAYS</b> LAST <b>WAYS</b>  |  | 15. MOTHER'S MAIDEN NAME FIRST <b>Elizabeth</b> MIDDLE <b>Bopst</b> LAST <b>Bopst</b>   |  | 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b> (IF YES, GIVE WAR OR DATES) <b>-</b>   |  |   |  |
| 16b SOCIAL SECURITY NO. <b>?</b>   |  | 17 INFORMANT <b>Ruby Shipley</b> ADDRESS <b>Marietta, Md.</b>   |  | 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: <b>3109</b> IMMEDIATE CAUSE (a) <b>Sepsis</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Multiple decubiti</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Chronic Brain Syndrome</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>days</b> <b>months</b> <b>years</b> |  |   |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a.  |  |   |  |   |  |   |  |
| 19a DATE OF OPERATION  |  | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M.</b> <b>19</b>   |  | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)   |  |   |  |
| 21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f LOCATION STREET CITY OR TOWN COUNTY STATE   |  |   |  |
| 22a I certify that (this hospital) attended the deceased from <b>3/8</b> 19 <b>82</b> , to <b>2/8</b> 19 <b>82</b> , that (we) last saw the deceased alive on <b>3/8</b> 19 <b>82</b> , and that (we) (our) opinion death occurred on the date and hour and from the causes stated above, (we) (did) (do not) view the body after death. |  |   |  |   |  |   |  |
| 22b SIGNATURE <b>J. Raymond Gladen, MD</b> DEGREE <b>MD</b> ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>   |  |   |  | 22c DATE SIGNED <b>2/8/82</b>   |  |   |  |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT) <b>J. Raymond Gladen</b>  |  |   |  | 22e ADDRESS <b>Balto. Md. Deaton Med. Center</b>  |  |   |  |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>   |  | 23b DATE <b>2-11-82</b>   |  | 23c NAME OF CEMETERY OR CREMATORY <b>Springfield Cemetery</b>   |  | 23d LOCATION CITY OR TOWN COUNTY STATE  |  |
| 24 FUNERAL DIRECTOR NAME <b>Harry W. Haight</b> ADDRESS <b>Sylacville, Md.</b>   |  |   |  | 25a DATE REC'D. BY REGISTRAR <b>FEB 11 1982</b>   |  | 25b REGISTRAR'S SIGNATURE <b>Russell J. Gladen</b>  |  |

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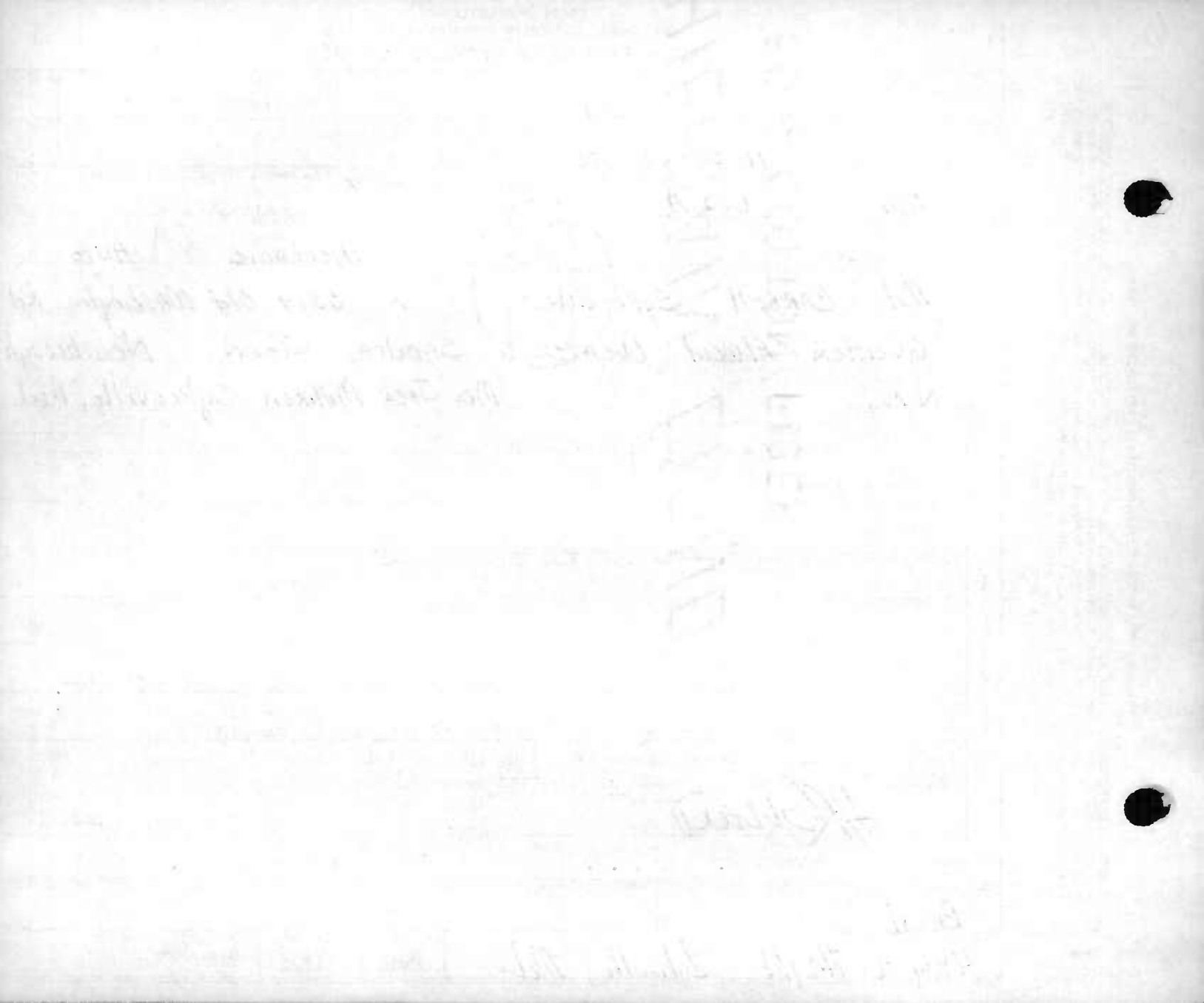
52

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM. 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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DHMH - 17  
(VR A15 ME (5))  
15M 2/80

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |  |                  |   |  |  |   |  |   |  | REG. NO. 8 2 0 4 3 1 8  |   |  |  |
|--|--|------------------|---|--|--|---|--|---|--|---|---|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br>BRIAN ELMWOOD WEAVER   |  |                  |   |  |  |   |  |   |  | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH DAY YEAR<br>2 26 1982 |   | 2b. HOUR<br>9:30 PM                            |  |
| 3. SEX<br>male   |  | 4. RACE<br>white |   | 5. DATE OF BIRTH MONTH DAY YEAR<br>11-20-61                            |  | 6. AGE (IN YEARS LAST BIRTHDAY) 20 YRS.   |  | 7. IF UNDER 1 YR. MONTHS DAYS HOURS MIN.  |  | 7c. DATE PRONOUNCED DEAD MONTH DAY YEAR<br>2 26 19 82                                   |   | 7d. HOUR<br>9:30 PM                            |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Md.   |  |                  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD                                    |   |   |  |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore   |  |                  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>University Hospital -STU |  |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Mechanic   |  |   | 12b. KIND OF BUSINESS OR INDUSTRY<br>Auto |  |  |
| 13a. STATE<br>Md.  |  |                  | 13b. COUNTY<br>Carroll  |  |  | 13c. CITY OR TOWN<br>Sykesville   |  |   | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |   | 13e. STREET ADDRESS<br>6319 Old Washington Rd. |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>Quenton Elwood Weaver   |  |                  |   |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Sandra Jean Newbrough   |  |   |  |   |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)<br>No   |  |                  |   | 16b. SOCIAL SECURITY NO.<br>?  |  | 17. INFORMANT ADDRESS<br>Mrs. Jack Milliron Sykesville, Md.   |  |   |  |   |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Multiple injuries<br>8151<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b) _____<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |                  |   |  |  |   |  |   |  |   |   |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |                  |   |  |  |   |  |   |  |   |   |  |  |
| 19a. DATE OF OPERATION   |  |                  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                      |  |   |  |   |  | 20. AUTOPSY? YES <input checked="" type="checkbox"/> (HO) <input type="checkbox"/>      |   |  |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  |                  |   | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>7:50PM 2/26 1982       |  |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)<br>passenger in auto/fixed object collision |  |   |   |  |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>  |  |                  |   | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)<br>roadway |  |   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE<br>Rt97So of BeechbarRd, CarrollCo MD                                      |  |   |   |  |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> (HO) <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |                  |   |  |  |   |  |   |  |   |   |  |  |
| ACTUAL SIGNATURE<br>H R Guard  |  |                  |   | TITLE (SPECIFY)<br>M.D. Assistant                                      |  |   |  | MEDICAL EXAMINER<br>DATE SIGNED 2/27/82   |  |   |   |  |  |
| EXAMINER'S NAME (TYPE OR PRINT)<br>Hormez R. Guard, M.D.   |  |                  |   | ADDRESS<br>111 Penn Street, Balto. MD 21201                            |  |   |  |   |  |   |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial  |  |                  |   | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY  |  |   | 23d. LOCATION CITY OR TOWN COUNTY STATE  |   |   |  |  |
| 24. FUNERAL DIRECTOR NAME<br>Harry W. Haight   |  |                  |   |  |  | ADDRESS<br>Sykesville, Md.  |  |   | 25a. DATE REC'D. BY REGISTRAR<br>MAR 3 1982  |   | 25b. REGISTRAR'S SIGNATURE                |  |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be applied at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  | 8 2 0 4 3 1 9   |  |   |  |
|--|--|---|--|---|--|---|--|
| 1. FOR STATE REGISTRAR   |  |   |  | REG. NO.  |  |   |  |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br><b>ELNA M CHEEK Webb</b>   |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>2 16 82</b>  |  |   |  |
| 3 SEX<br><b>Female</b>   |  | 4 RACE<br><b>Black</b>  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>4 12 44</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS<br><b>37 YRS.</b>   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MD</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City MD.</b>   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Union Memorial Hosp.</b> |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)   |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |   |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |   |  |
| 13a. STATE<br><b>MD</b>  |  | 13b. COUNTY   |  | 13c. CITY OR TOWN<br><b>Baltimore</b>   |  | 13e. STREET ADDRESS<br><b>5505 Bowleys Lane</b>   |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>Richard Iles</b>   |  |   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Ida Cornish</b>  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><b>No</b>   |  | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)<br><b>219-38-4395</b>  |  | 17. INFORMANT ADDRESS<br><b>Nora Alford 1505 Kingsway Rd.</b>   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line, or (a), (b), and (c). PART I. DEATH WAS CAUSED BY:<br><b>9100</b><br>IMMEDIATE CAUSE (a) <b>Acute Myocardial Infarction</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) _____<br>DUE TO, OR AS A CONSEQUENCE OF (c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |   |  |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) _____  |  |   |  |   |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost <sup>now the deceased alive on</sup> above. (I) (we) did <sup>not</sup> attend <sup>the</sup> body after death. _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated                   |  |   |  |   |  |   |  |
| 22b. SIGNATURE<br><b>Walter Burkhes</b>  |  |   |  | DEGREE<br><b>MD</b>   |  | 22c. DATE SIGNED<br><b>2-16-82</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>WALTER BURKHES, MD</b>   |  |   |  | 22e. ADDRESS<br><b>UNION MEMORIAL HOSP</b>  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>2/19/82</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>King Memorial Pk.</b>  |  | 23d. LOCATION CITY OR TOWN COUNTY<br><b>Baltimore Co. MD</b>  |  |
| 24. FUNERAL DIRECTOR NAME<br><b>Wm. C. March F/H</b>   |  |   |  | ADDRESS<br><b>1101 E. North Ave.</b>  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>FEB 17 1982</b>   |  |
|  |  |   |  |   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Thane J. [Signature]</b>   |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Item 6 g566 4/21/82 gj

FOR  
1. STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 4 3 2 0

REG. NO.

|  |   |  |  |   |   |
|--|---|--|--|---|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>NELLIE G WEBB</b>   |   |  | 2a. DATE OF DEATH<br>MONTH <b>2</b> DAY <b>25</b> YEAR <b>82</b>               |   | 2b. HOUR <b>8:00</b> M  |
| 3. SEX<br><b>Female</b>  | 4. RACE<br><b>Black</b>   | 5. DATE OF BIRTH<br>MONTH <b>4</b> DAY <b>1</b> YEAR <b>08</b>   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>74-73</b> YRS.                           |   | IF UNDER 1 YEAR<br>MONTHS <b>7</b> DAYS <b>10</b>   |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br><b>N.C.</b>  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>    | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.              |   |   |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>John Deaton Med. Center</b> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)               |   | 12b. KIND OF BUSINESS OR INDUSTRY   |
| 13a. STATE<br><b>Md.</b>   |   | 13b. COUNTY<br><b>Balto.</b>   | 13c. CITY OR TOWN<br><b>Balto.</b>   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS<br><b>1858 E. Chase Street</b>  |
| 4. FATHER'S NAME<br>FIRST <b>Sampson</b> MIDDLE <b>Kitrell</b> LAST <b>Kitrell</b>   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>Lillie</b> MIDDLE <b>Melvin</b> LAST <b>Melvin</b>  |  |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>  |   | 16b. SOCIAL SECURITY NO.<br><b>215-48-4894</b>   |  | 17. INFORMANT<br>ADDRESS<br><b>Vernon J. Webb 1858 E. Chase St.</b>                             |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>C.V.A. - Hypertension</b><br>4360<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Peripheral Vascular Disease</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>H.E.V.D.</b>                  |   |  |  |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br><b>5 years</b><br><b>5 years</b><br><b>20 years</b>                        |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1  |   |  |  |   |   |
| 19a. DATE OF OPERATION   |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |   |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |   |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>12/1/81</b> to <b>2/25/82</b> that (I) (we) last saw the deceased alive on <b>8/25/82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |   |  |  |   |   |
| 22b. SIGNATURE<br><b>Paul Schmfield MD</b>   |   | DEGREE <b>MD</b><br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br><b>2/25/82</b>  |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>PAUL Schmfield</b>   |   | 22e. ADDRESS<br><b>407 Crum Highway Glen Burnie</b>  |  |   |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  | 23b. DATE<br><b>3/2/82</b>  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Arbutus Mem. Park</b>   |  | 23d. LOCATION<br>CITY OR TOWN<br><b>Arbutus, Md.</b>  | COUNTY STATE  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Wm C March F/H, Inc.</b>  |   | ADDRESS<br><b>1101 E. North Ave.</b>   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>MAR 1 1982</b>  | 25b. REGISTRAR'S SIGNATURE<br><b>Frances Jean N...</b>  |



5

*[Faint, illegible handwriting throughout the page, possibly bleed-through from the reverse side.]*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  | 8 2 0 4 3 2 1  |  |   |  |
|---|--|---|--|--|--|---|--|
| 1. FOR STATE REGISTRAR  |  |   |  | REG. NO.   |  |   |  |
| 1. DECEASED NAME (TYPE OR PRINT) <b>Frances T. Weber</b>  |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR <b>February 14, 1982</b>  |  | 2b. HOUR <b>M</b>   |  |
| 3. SEX <b>Female</b>  |  | 4. RACE <b>Caucasian</b>  |  | 5. DATE OF BIRTH MONTH DAY YEAR <b>Sept 3, 1912</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY) <b>69</b>   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Id</b>   |  | 7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>       |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.  |  |
| 10. CITY OR TOWN OF DEATH <b>Baltimore</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>2210 Portugal St.</b> |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Homemaker</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>   |  |
| 13a. STATE <b>Id</b>  |  | 13b. COUNTY <b>Baltimore</b>  |  | 13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 13d. STREET ADDRESS <b>2210 Portugal St.</b>  |  |
| 14. FATHER'S NAME (TYPE OR PRINT) <b>Frank</b>  |  | 15. MOTHER'S MAIDEN NAME (TYPE OR PRINT) <b>Wagner</b>  |  | 16. SOCIAL SECURITY NO. <b>212-10-5538</b>   |  | 17. INFORMANT'S NAME AND ADDRESS <b>Harry Weber 2210 Portugal St.</b>   |  |
| 18. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>  |  | 19. IF YES, GIVE WAR OR DATES   |  | 20. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of lung, right</b> 1629 |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost   |  | (b) <b>Extensive metastases</b>   |  | (c) <b>pulmonary failure</b>   |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |   |  |  |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |   |  |
| 22. I certify that (I) (this hospital) attended the deceased from <b>8/6/80</b> , 19 <b>80</b> , to <b>2/13/82</b> , 19 <b>82</b> , that (I) (we) lost saw the deceased alive on <b>11/9/82</b> , 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death. |  |   |  |  |  |   |  |
| 22b. SIGNATURE <b>Hilbert M. Levine MD</b>  |  |   |  | DEGREE <b>MD</b>   |  | 22c. DATE SIGNED <b>2/15/82</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Hilbert M. Levine, M.D.</b>  |  |   |  | 22e. ADDRESS <b>333 Saint Paul Place</b>   |  | 22f. CITY OR TOWN <b>Baltimore</b> STATE <b>Id</b>  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>   |  | 23b. DATE <b>2-17-82</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY <b>St. Stanislaus</b>   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore City Id</b>  |  |
| 24. FUNERAL DIRECTOR NAME <b>Raymond J. Kozmowski</b> ADDRESS <b>2525 4th St.</b>   |  |   |  | 25a. DATE REC'D. BY REGISTRAR <b>FEB 17 1982</b>   |  | 25b. REGISTRAR'S SIGNATURE <b>Ann J. [Signature]</b>  |  |

From the University of Chicago

Dear Sir,  
I have the honor to acknowledge the receipt of your letter of the 11th inst. and in reply to inform you that the same has been forwarded to the proper authorities for their consideration.  
Very respectfully,  
Your obedient servant,  
J. H. [Name]  
[Address]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be called on.

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 4 3 2 2

REG. NO.

|  |  |  |   |   |  |   |  |  |  |  |
|--|--|--|---|---|--|---|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>LOUIS H. WEBER SR.</b>   |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>09-20-82</b>  |   |  | 2b. HOUR<br>M   |  |  |  |  |
| 3. SEX<br><b>Male</b>  |  | 4. RACE<br><b>White</b>  |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Oct. 12, 1937</b>  |  | 6. AGE (IN YEARS (LAST BIRTHDAY))<br><b>44</b>  |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.   |  |  |
| 8. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br><b>MD</b>   |  | 9b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |   | 10. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>        |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE City MD.</b>   |  |  | 11. BALTIMORE CITY OR COUNTY OF DEATH          |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>SOUTH BALTIMORE G.H.</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Printer</b>  |  |   | 12b. KIND OF BUSINESS, OR INDUSTRY<br><b>Service Comp.</b> |  |  |  |
| 13a. STATE<br><b>MD</b>  |  | 13b. COUNTY<br><b>A.A.</b>   |   | 13c. CITY OR TOWN<br><b>Baltimore</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                 |  | 13e. STREET ADDRESS<br><b>127 W EDGEVALE RD</b>  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>HENRY A. WEBER</b>  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>MILDRED L. HARBERT</b>  |   |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NAME OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>NO</b> |  |  | 16b. SOCIAL SECURITY NO.<br><b>212-36-9354</b> |  |
| 17. INFORMANT<br>ADDRESS<br><b>Julia A. Weber (same as 13e)</b>  |  |  | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>MIOCARDIAL INFARCTION</b><br><b>3229</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>SEPSIS</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>MENINGITIS</b> |   |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH   |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a<br><b>Diabetes - Abscess of right foot.</b>   |  |  |   |   |  |   |  |  |  |  |
| 19a. DATE OF OPERATION<br><b>2/16/82</b>   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>DRAINAGE OF FOOT ABSCESS</b>  |   |   |  | 19c. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |  |   |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |  |  |  |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>2/12</b> , 19 <b>82</b> , to <b>2/20</b> , 19 <b>82</b> , that <input checked="" type="checkbox"/> (we) lost<br>saw the deceased alive on <b>2/20</b> , 19 <b>82</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated<br>above, <input checked="" type="checkbox"/> (we) (did not) view the body after death. |  |  |   |   |  |   |  |  |  |  |
| 22b. SIGNATURE<br><b>Armando Sarai</b>   |  |  |   | DEGREE<br><b>M.D.</b><br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  |   |  | 22c. DATE SIGNED   |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>ARMANDO SARAI</b>  |  |  |   | 22e. ADDRESS<br><b>SB6H.</b>  |  |   |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(STATE)<br><b>Burial</b>  |  | 23b. DATE<br><b>2/24/1982</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Glen Haven Memorial</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Md.</b>  |  |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>George J. Gonce F.H. 4001 Ritchie Hwy.</b>  |  |  |   | 25a. DATE REC'D. BY REGISTRAR<br><b>FEB 25 1982</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>James J. Wether</b>  |  |  |  |  |

MEDICAL CERTIFICATION

07 314V3803 W 751

STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2

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1 - FOR  
STATE  
REGISTRAR

REG. NO.

|   |  |  |   |   |  |  |  |   |  |
|---|--|--|---|---|--|--|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>WILLIAM E. WEBER</b>   |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>FEBRUARY 19, 1982</b> |   | 2b. HOUR<br><b>10:15 AM</b>  |  |  |   |  |
| 3. SEX<br><b>Male</b>   |  | 4. RACE<br><b>White</b>  |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>1 9 04</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>YRS. MONTHS DAYS<br><b>78</b>         |  |   |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br><b>MD</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. <b>BALTIMORE CITY</b> OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD. |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>THE JOHNS HOPKINS HOSPITAL</b> |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)                     |  | 12b. KIND OF BUSINESS OR INDUSTRY  |   |  |
| 13a. STATE<br><b>MD</b>   |  |  |   | 13b. COUNTY   |  | 13c. CITY OR TOWN<br><b>Baltimore</b>                                    |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Otto Weber</b>   |  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Mabel Black</b>   |  |  |  | 13e. STREET ADDRESS<br><b>1804 N. Gay St.</b>   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>No</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>216-05-2221</b>   |   | 17. INFORMANT<br><b>Alverta Weber</b>   |  |  |  | ADDRESS<br><b>1804 N. Gay St.</b>   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiorespiratory Arrest</b><br><b>1850</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Metastatic Prostatic Cancer</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>6 months</b>  |  |  |   |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>6 months</b>                                 |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (c)<br><b>Chronic obstructive lung disease</b>   |  |  |   |   |  |  |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |   |  |
| 22a. I certify that (1) this hospital attended the deceased from <b>Feb 1</b> , 19 <b>82</b> , to <b>Feb 19</b> , 19 <b>82</b> , that (1) (we) lost<br>saw the deceased alive on <b>Feb 19</b> , 19 <b>82</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated<br>above; (1) (we) (did not) view the body after death. |  |  |   |   |  |  |  |   |  |
| 22b. SIGNATURE<br><b>(C. Mitchell Gilbert MD)</b>   |  |  |   | DEGREE  |  |  |  | 22c. DATE SIGNED<br><b>2/19/82</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Mitchell Gilbert MD</b>   |  |  |   | 22e. ADDRESS<br><b>Johns Hopkins Hospital</b>   |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>2/24/82</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Parkwood Cem.</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Co. MD</b>    |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Wm. C. March F/H</b>   |  |  |   | ADDRESS<br><b>1101 E. North Ave.</b>  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>FEB 24 1982</b>                      |  |   |  |
|   |  |  |   |   |  | REGISTRAR'S SIGNATURE<br><b>James J. [Signature]</b>                     |  |   |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: This certificate requires that the death certificate be executed within 24 hours of death. Page 2, reverse, retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be completely filled in by the funeral director and should be detached for use as the burial-transit permit. Then please remove carbon copies to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. **01/20/19**

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified in person.

TO IT

RECEIVED

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  |   |   |  |   |   |  |
|--|--|---|--|---|---|--|---|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <u>James</u> <u>Webster</u>  |  |   |  |   | REG. NO.  |  |   |   |  |
| 2a. DATE OF DEATH <u>2/19/82</u>   |  |   |  |   | 2b. HOUR <u>7 pm</u>  |  |   |   |  |
| 3. SEX <u>M</u>  |  | 4. RACE <u>BLK</u>  |  | 5. DATE OF BIRTH <u>10 15 35</u>  |   | 6. AGE (IN YEARS (LAST BIRTHDAY)) <u>46</u>  |   | IF UNDER 1 YEAR<br>MONTHS DAYS  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>MD</u>  |  | 7b. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH <u>City</u> MD  |   |   |  |
| 10. CITY OR TOWN OF DEATH <u>Balto</u>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>Balto City Hosp</u> |  |   |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                                |   | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| 13a. STATE <u>MD</u>   |  | 13b. COUNTY <u>Balto</u>  |  | 13c. CITY OR TOWN <u>Balto</u>  |   | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   | 13e. STREET ADDRESS <u>6612 Laurel Drive</u>  |  |
| 14. FATHER'S NAME <u>James</u> <u>Webster</u>  |  |   |  |   | 15. MOTHER'S MAIDEN NAME <u>Katie</u>   |  |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES NO OR UNKNOWN)   |  |   |  |   | 16b. SOCIAL SECURITY NO. <u>215-30-445</u>  |  | 17. INFORMANT <u>Elaine V. Webster</u> ADDRESS <u>6612 Laurel Drive</u> |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for 1a), 1b), and 1c).<br>PART I. DEATH WAS CAUSED BY:<br><u>0389</u> IMMEDIATE CAUSE (a) <u>Sepsis</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause 1a), stating the underlying cause last }<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 wk.</u> |  |   |  |   |   |  |   |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><u>Immuno-suppression</u>   |  |   |  |   |   |  |   |   |  |
| 19a. DATE OF OPERATION   |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   |   | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>            |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)               |   |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  |   | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |   |   |  |
| 22a. I certify that (1) this hospital attended the deceased from <u>2/1</u> , 19 <u>82</u> , to <u>2/19</u> , 19 <u>82</u> , that (1) (we) lost <u>saw the deceased alive on 2/19</u> , 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (1) (we) (did not) view the body after death.   |  |   |  |   |   |  |   |   |  |
| 22b. SIGNATURE <u>M. Nelson</u>  |  |   | DEGREE <u>M.D.</u><br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   |   | 22c. DATE SIGNED <u>2/19/82</u>  |   |   |  |
| 22d. PHYSICIAN'S NAME (IF DIFFERENT)<br><u>Marc Nelson</u>   |  |   | 22e. ADDRESS<br><u>Balt. City Hosp.</u>  |   |   |  |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY) <u>Burial</u>   |  |   | 23b. DATE <u>2/25/82</u>   |   | 23c. NAME OF CEMETERY OR CREMATORY <u>Arbutus</u>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><u>Balto MD</u>           |   |  |
| 24. FUNERAL DIRECTOR<br>NAME <u>VERNON B. Bailey</u> ADDRESS <u>1348 N. Calton</u>   |  |   |  |   | 25a. DATE REC'D. BY REGISTRAR <u>FEB 23 1982</u> 25b. REGISTRAR'S SIGNATURE <u>Thom J. Hester</u> |  |   |   |  |



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

|   |                  |  |   |   |   |   |   |   |  |
|---|------------------|--|---|---|---|---|---|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Godfrey Weedon   |                  |  | 2a. DATE KNOWN OF DEATH<br>ESTIMATED<br>2 1 1982            |   |   | 2b. HOUR<br>M   |   |   |  |
| 3. SEX<br>Male  | 4. RACE<br>Black | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>4 20 1933  | 6. AGE IN YEARS<br>(LAST BIRTHDAY)<br>48 YRS.               | IF UNDER 1 YR.<br>MONTHS DAYS   | IF UNDER 24 HRS.<br>HOURS MIN.  | 2c. DATE PRONOUNCED DEAD<br>2 1 1982  |   |   | 2d. HOUR<br>11:30<br>P M                     |
| 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland  |                  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City, MD.                                     |   |   |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore  |                  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>St. Agnes Hospital |   |   |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Laborer                        |   | 12b. KIND OF BUSINESS OR INDUSTRY<br>Constuction                                    |  |
| 13a. STATE<br>Maryland  |                  | 13b. COUNTY<br>Frederick   |   | 13c. CITY OR TOWN<br>Frederick  |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   | 13e. STREET ADDRESS<br>116 Ice St.  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Thomas Fulton Weedon  |                  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Anna A. Johnson  |   |   |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br>Yes  |                  | 16b. SOCIAL SECURITY NO.<br>Korean   |   | 17. INFORMANT<br>Mary Weedon  |   | 17b. ADDRESS<br>116 Ice St. Frederick, Md.  |   |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardiovascular disease</u><br>4292<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.<br>(b) _____<br>(c) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>DUE TO, OR AS A CONSEQUENCE OF   |                  |  |   |   |   |   |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).   |                  |  |   |   |   |   |   |   |  |
| 19a. DATE OF OPERATION  |                  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?           |   |   |   |   | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |                  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |   |   |   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |                  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                             |   |   |   |  |
| 22a. I certify that I took charge of the remains described above, had an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |                  |  |   |   |   |   |   |   |  |
| ACTUAL SIGNATURE<br>Thomas D. Smith   |                  |  | TITLE (SPECIFY)<br>M.D. Deputy Chief                        |   |   | MEDICAL EXAMINER  |   | DATE SIGNED<br>2/2/82   |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)<br>Thomas D. Smith, M.D.   |                  |  | ADDRESS<br>111 Penn St. Balto., MD.                         |   |   |   |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial   |                  | 23b. DATE<br>1/5/82  |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Resthaven Mem. Gar.   |   |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Frederick, Frederick, Md. |   |  |
| 24. FUNERAL DIRECTOR<br>E. Douglas Stauffer   |                  |  | Rt. 10 Box 66<br>Frederick Md.                              |   |   | 25. DATE REC'D BY REGISTRAR<br>FEB 11 1982  |   |   |  |

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 7 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH   |  |         |  |  |  |   |  |   |  | REG. NO.            |          |   |         |  |         |  |  |
|---|--|---------|--|--|--|---|--|---|--|---------------------|----------|---|---------|--|---------|--|--|
| 1. FOR STATE REGISTRAR  |  |         |  |  |  | 2. DATE KNOWN OF DEATH                                      |  |   |  |                     | 3. MONTH | 4. DAY  | 5. YEAR | 6. HOUR                                      |         |  |  |
| 1. DECEASED NAME (TYPE OR PRINT)  |  |         |  |  |  | 2. DATE KNOWN OF DEATH                                      |  |   |  |                     |          | 3. MONTH  | 4. DAY  | 5. YEAR                                      | 6. HOUR |  |  |
| August J. Weiss   |  |         |  |  |  | 2. DATE KNOWN OF DEATH                                      |  |   |  |                     |          | 3. MONTH  | 4. DAY  | 5. YEAR                                      | 6. HOUR |  |  |
| 3. SEX  |  | 4. RACE |  | 5. DATE OF BIRTH   |  | 6. AGE (IN YEARS)   |  | 7. IF UNDER 1 YR.   |  | 8. IF UNDER 24 HRS. |          | 9. DATE PRONOUNCED DEAD   |         | 10. HOUR                                     |         |  |  |
| Male  |  | White   |  | Jan. 22, '98   |  | 84 YRS.   |  | MONTHS  |  | DAYS                |          | HOURS   |         | 12:02 P M                                    |         |  |  |
| 11. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  |         |  | 12. CITIZEN OF WHAT COUNTRY?                             |  |   |  | 13. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |                     |          | 14. BALTIMORE CITY OR COUNTY OF DEATH   |         |  |         |  |  |
| Pa.   |  |         |  | USA  |  |   |  |   |  |                     |          | Baltimore City, MD.   |         |  |         |  |  |
| 15. CITY OR TOWN OF DEATH   |  |         |  | 16. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION |  |   |  | 17. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |  |                     |          | 18. KIND OF BUSINESS OR INDUSTRY  |         |  |         |  |  |
| Baltimore   |  |         |  | University Hospital                                      |  |   |  | Mechanical Engineer   |  |                     |          | Glass   |         |  |         |  |  |
| 19. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |         |  |  |  | 20. INSIDE CITY LIMITS?                                     |  |   |  |                     |          | 21. STREET ADDRESS  |         |  |         |  |  |
| 13a. STATE  |  |         |  |  |  | 13b. CITY OR TOWN   |  |   |  |                     |          | 13c. STREET ADDRESS   |         |  |         |  |  |
| Md.   |  |         |  |  |  | Baltimore   |  |   |  |                     |          | 242 Rodgers Forge Road  |         |  |         |  |  |
| 22. FATHER'S NAME   |  |         |  |  |  | 23. MOTHER'S MAIDEN NAME                                    |  |   |  |                     |          |   |         |  |         |  |  |
| Nicholas Weiss  |  |         |  |  |  | Gertrude Klaes  |  |   |  |                     |          |   |         |  |         |  |  |
| 24. WAS DECEASED EVER IN U.S. ARMED FORCES?   |  |         |  |  |  | 25. SOCIAL SECURITY NO.                                     |  |   |  |                     |          | 26. INFORMANT ADDRESS   |         |  |         |  |  |
| No  |  |         |  |  |  | 215 10 0937A  |  |   |  |                     |          | Dr. Harold Weiss 407 Cedarcroft Rd.   |         |  |         |  |  |
| 19. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |  |         |  |  |  |   |  |   |  |                     |          |   |         | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |         |  |  |
| PART I DEATH WAS CAUSED BY:   |  |         |  |  |  |   |  |   |  |                     |          |   |         |  |         |  |  |
| IMMEDIATE CAUSE (a) Multiple injuries   |  |         |  |  |  |   |  |   |  |                     |          |   |         |  |         |  |  |
| 8147  |  |         |  |  |  |   |  |   |  |                     |          |   |         |  |         |  |  |
| DUE TO, OR AS A CONSEQUENCE OF  |  |         |  |  |  |   |  |   |  |                     |          |   |         |  |         |  |  |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.   |  |         |  |  |  |   |  |   |  |                     |          |   |         |  |         |  |  |
| (b) DUE TO, OR AS A CONSEQUENCE OF  |  |         |  |  |  |   |  |   |  |                     |          |   |         |  |         |  |  |
| (c)   |  |         |  |  |  |   |  |   |  |                     |          |   |         |  |         |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).   |  |         |  |  |  |   |  |   |  |                     |          |   |         |  |         |  |  |
| 19a. DATE OF OPERATION  |  |         |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?           |  |   |  |                     |          | 20. AUTOPSY?  |         |  |         |  |  |
|   |  |         |  |  |  |   |  |   |  |                     |          | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>           |         |  |         |  |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  |         |  |  |  | 21b. TIME OF INJURY   |  |   |  |                     |          | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |         |  |         |  |  |
|   |  |         |  |  |  | 10:40x 2 22 19 82   |  |   |  |                     |          | Pedestrian struck by auto   |         |  |         |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK  |  |         |  |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) |  |   |  |                     |          | 21f. LOCATION   |         |  |         |  |  |
|   |  |         |  |  |  | street  |  |   |  |                     |          | E. Joppa Rd. w. of Virginia Ave. Towson, Balto.                               |         |  |         |  |  |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |  |         |  |  |  |   |  |   |  |                     |          |   |         |  |         |  |  |
| ACTUAL SIGNATURE  |  |         |  |  |  | TITLE (SPECIFY)   |  |   |  |                     |          | DATE SIGNED   |         |  |         |  |  |
| Thomas D. Smith, M.D.   |  |         |  |  |  | M.D. Deputy Chief   |  |   |  |                     |          | 2/23/82   |         |  |         |  |  |
| EXAMINER'S NAME (TYPE OR PRINT)   |  |         |  |  |  | ADDRESS   |  |   |  |                     |          |   |         |  |         |  |  |
| Thomas D. Smith, M.D.   |  |         |  |  |  | 111 Penn St. Balto., MD.                                    |  |   |  |                     |          |   |         |  |         |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |  |         |  |  |  | 23b. DATE   |  |   |  |                     |          | 23c. NAME OF CEMETERY OR CREMATORY  |         |  |         |  |  |
| Burial  |  |         |  |  |  | 2/25/82   |  |   |  |                     |          | Dulaney Valley Mem. Gdns.   |         |  |         |  |  |
| 23d. LOCATION   |  |         |  |  |  | 23e. COUNTY   |  |   |  |                     |          | 23f. STATE  |         |  |         |  |  |
| Cockeysville, Md.   |  |         |  |  |  |   |  |   |  |                     |          | Md.   |         |  |         |  |  |
| 24. FUNERAL DIRECTOR  |  |         |  |  |  | 25. DATE RECEIVED BY REGISTRAR                              |  |   |  |                     |          | 26. REGISTRAR'S SIGNATURE   |         |  |         |  |  |
| MITCHELL-WIEDEFELD HOME, INC.   |  |         |  |  |  | 61582   |  |   |  |                     |          | Handwritten Signature   |         |  |         |  |  |
| 6500 York Rd.   |  |         |  |  |  |   |  |   |  |                     |          |   |         |  |         |  |  |

1. The first part of the report is a general statement of the situation.

2. The second part of the report is a detailed statement of the situation.

3. The third part of the report is a detailed statement of the situation.

4. The fourth part of the report is a detailed statement of the situation.

5. The fifth part of the report is a detailed statement of the situation.

6. The sixth part of the report is a detailed statement of the situation.

7. The seventh part of the report is a detailed statement of the situation.

8. The eighth part of the report is a detailed statement of the situation.

9. The ninth part of the report is a detailed statement of the situation.

10. The tenth part of the report is a detailed statement of the situation.

11. The eleventh part of the report is a detailed statement of the situation.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  | REG. NO.  |  |   |   |
|---|--|--|--|---|--|---|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>Evelyn L. WELCH</b>  |  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>February 2, 1982</b>   |  |   |   |
| 3. SEX<br><b>female</b>   |  |  |  | 4. RACE<br><b>white</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>July 31, 1915</b>  |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Penn.</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                          |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>66</b> YRS  |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.  |   |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   |  |  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Maryland General Hospital</b>                     |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.   |   |
| 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Home Maker</b>   |  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |   |   |
| 13a. STATE<br><b>MD</b>   |  |  |  | 13b. CITY OR TOWN<br><b>Balto.</b>  |  | 13c. STREET ADDRESS<br><b>3527 Cabot Rd.</b>  |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Richard A. Fulton</b>  |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Phoebe Litten</b>   |  |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>No</b>   |  |  |  | 16b. SOCIAL SECURITY NO.<br><b>176-07-5593</b>  |  | 17. INFORMANT<br><b>Mr. J. Thomas Welch</b><br>ADDRESS<br><b>3527 Cabot Rd.</b>   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br><b>Lymphoma</b><br>IMMEDIATE CAUSE (a)<br><b>2028</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b)<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)  |  |  |  |   |  |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)  |  |  |  |   |  |   |   |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>      |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |   |
| 21d. INJURY OCCURRED<br>AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |   |
| 22a. I certify that (this hospital) attended the deceased from <b>February 1, 1982</b> , to <b>February 2, 1982</b> , that (X) (we) last saw the deceased alive on <b>February 2, 1982</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, X (we) (did) (view the body after death). |  |  |  |   |  |   |   |
| 22b. SIGNATURE<br><b>Eric Fisher</b>  |  |  |  | DEGREE<br><b>MD</b><br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br><b>2/2/82</b>   |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Eric Fisher, M.D.</b>   |  |  |  | 22e. ADDRESS<br><b>c/o Maryland General Hospital</b>  |  |   |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Cremation</b>  |  | 23b. DATE<br><b>2/5/82</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Loudon Park Crematory</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore City MD</b>  |   |
| 24. FUNERAL DIRECTOR<br><b>Loring Byers Funeral Directors</b><br>NAME ADDRESS<br><b>8728 Liberty Rd. Randallstown, Md. 21133</b>  |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>FEB 4 1982</b>  |  |   |   |
|   |  |  |  | 25b. REGISTRAR'S SIGNATURE<br><b>James J. Nathan</b>  |  |   |   |



14

Director of Maryland General Hospital

Attorney General

February 2, 1932

1932

Wash

Lynchburg

XX

Dr. J. E. L. L. L. L.

February 1

February 2

1932

Director of Maryland General Hospital

Feb 4 1932

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified by the funeral director.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |   |  |   |  |  |                                   | REG. NO.   |  |
|--|--|--|--|---|--|---|--|--|-----------------------------------|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>HARRY DONALD WELCH</b>  |  |  |  |   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR <b>FEB 28 1982</b>  |  |  |                                   | 2b. HOUR<br>M  |  |
| 3. SEX<br><b>M</b>   |  | 4. RACE<br><b>N</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR <b>7/29/24</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>57</b> YRS.   |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.  |                                   | IF UNDER 24 HRS.<br>HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Baltimore Md.</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>         |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City MD.</b>                               |  |  |                                   |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>St. Agnes Hospital Baltimore</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Self - Employed</b>      |  |  | 12b. KIND OF BUSINESS OR INDUSTRY |  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |  |  |   |  |   |  |  |                                   |  |  |
| 13a. STATE<br><b>Md.</b>   |  | 13b. COUNTY<br><b>BALTO.</b>   |  | 13c. CITY OR TOWN<br><b>Catonsville</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>19 Garnet Ave.</b>   |                                   |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Harry A. Welch</b>  |  |  |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Edna Brown</b>                              |  |  |                                   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>W.W. II</b>   |  |  |  | 16b. SOCIAL SECURITY NO.  |  | 17. INFORMANT<br>ADDRESS<br><b>Palestine Welch, 19 Garnet Ave.</b>                              |  |  |                                   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>MARKED PULMONARY EDEMA</b><br><b>4100</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>CORONARY THROMBOSIS - LEFT ANT. DESCENDING</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>ATHEROSCLEROSIS - GENERALIZED</b> |  |  |  |   |  |   |  |  |                                   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br><b>1 HOUR</b>   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |  |  |   |  |   |  |  |                                   |  |  |
| 19a. DATE OF OPERATION   |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                   | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                  |  |  |                                   |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |                                   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                            |  |  |  |   |  |   |  |  |                                   |  |  |
| 22b. SIGNATURE<br><b>James E. Taylor</b>   |  |  |  | DEGREE<br><b>M.D.</b><br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  |   |  | 22c. DATE SIGNED<br><b>3/1/82</b>  |                                   |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>JAMES E. TAYLOR</b>  |  |  |  | 22e. ADDRESS<br><b>ST AGNES HOSPITAL</b>  |  |   |  |  |                                   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |  |  |  | 23b. DATE<br><b>3/4/82</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Arbutus Mem. Park</b>                                  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore, Maryland</b>             |                                   |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Law Funeral Home 4611 Park Heights Ave.</b>   |  |  |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>MAR 3 1982</b>  |  |  |                                   |  |  |

level to read the following:

[illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a post-mortem examination must be made.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  | REG. NO. 82 04329  |  |   |  |
|--|--|---|--|--|--|---|--|
| 1. FOR STATE REGISTRAR   |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR 2 16 82   |  |   |  |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST James Melling   |  | 2b. HOUR 6 <sup>30</sup> M  |  | 3. SEX M   |  | 4. RACE Black   |  |
| 5. DATE OF BIRTH MONTH DAY YEAR 10 23 13   |  | 6. AGE (IN YEARS LAST BIRTHDAY) 78 YRS                                  |  | 7. IF UNDER 1 YEAR MONTHS DAYS   |  | 8. IF UNDER 24 HRS HOURS MIN.   |  |
| 9. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Baltimore Md  |  | 10. CITY OR TOWN OF DEATH Maryland                                      |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Cator Manor Hosp Center |  | 12. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD   |  |
| 13. MARried <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>  |  | 14. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) RETIRED    |  | 15. KIND OF BUSINESS OR INDUSTRY MAINT. ENGINEER   |  |   |  |
| 16. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 35 Calverton Baltimore   |  | 17. CITY OR TOWN Catorville   |  | 18. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                    |  | 19. STREET ADDRESS 313-A Melvin Ave   |  |
| 20. FATHER'S NAME FIRST MIDDLE LAST James Melling  |  | 21. MOTHER'S MAIDEN NAME FIRST MIDDLE BUTLER                            |  | 22. 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO   |  | 23. 16b. SOCIAL SECURITY NO. 212-20-8260  |  |
| 24. 17. INFORMANT MRS. HAZEL MATTHEWS  |  | 25. ADDRESS 1 ROBERT AVENUE   |  | 26. 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |  | 27. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |
| 28. PART 1: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4140 CARDIO PULMONARY ARREST.   |  | 29. DUE TO, OR AS A CONSEQUENCE OF (b) ARTERIO SCLEROTIC HEART DISEASE  |  | 30. DUE TO, OR AS A CONSEQUENCE OF (c)   |  | 31. PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: PAGETS DISEASE |  |
| 32. 19a. DATE OF OPERATION   |  | 33. 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                    |  | 34. 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 35. 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>                         |  |
| 36. 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 37. 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19                |  | 38. 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART 1 OR PART 2)   |  |   |  |
| 39. 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  | 40. 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 41. 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |   |  |
| 42. 22a. I certify that (I) (this hospital) attended the deceased from 2/16 19 82, to 2/19 19 82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |  |  |  |   |  |
| 43. 22b. SIGNATURE Surgeon A. J. J. M.D.   |  | 44. 22c. DATE SIGNED 2/19/82  |  | 45. 22d. PHYSICIAN'S NAME (TYPE OR PRINT) SURJIT S. JULKA  |  | 46. 22e. ADDRESS 107-109 E. Saratoga St. Baltimore 21202  |  |
| 47. 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL   |  | 48. 23b. DATE 2/19/82   |  | 49. 23c. NAME OF CEMETERY OR CREMATORY ARBUTUS MEMORIAL PARK   |  | 50. 23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE (BALTO.) MD.  |  |
| 51. 24. FUNERAL DIRECTOR NAME LEWIS T. GWYNN   |  | 52. ADDRESS 4517 PARK HEIGHTS AVENUE                                    |  | 53. 25a. DATE REC'D. BY REGISTRAR FEB 22 1987  |  | 54. 25b. REGISTRAR'S SIGNATURE [Signature]  |  |

1517 PARK HEIGHTS AVENUE

834

RECEIVED 2/19/85 BUREAU OF INVESTIGATION FEDERAL BUREAU OF INVESTIGATION (BUREAU)

x

1517 PARK HEIGHTS AVENUE

RECEIVED

FEDERAL BUREAU OF INVESTIGATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  |  |  |   |  |  |  | REG. NO. |  |
|---|--|---|--|--|--|---|--|--|--|----------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><u>Mr. Edward J Wells</u>   |  |   |  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><u>2-12-82</u>   |  | 2b. HOUR<br><u>2:25</u> AM   |  |          |  |
| 3. SEX<br><u>MALE</u>   |  | 4. RACE<br><u>Negro</u>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><u>8 17 29</u>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><u>52</u> YRS.   |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.   |  |          |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><u>MARYLAND</u>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.</u>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>    |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><u>Baltimore City</u> MD.                               |  |  |  |          |  |
| 10. CITY OR TOWN OF DEATH<br><u>BALTIMORE</u>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT INSURE FACILITY, GIVE STREET ADDRESS)<br><u>BON SECOURS Hospital</u> |  |  |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><u>Maintenance worker</u>   |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |          |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><u>MARYLAND</u>   |  | 13b. COUNTY<br><u>BALTIMORE</u>   |  | 13c. CITY OR TOWN<br><u>BALTIMORE</u>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><u>748 N. Grantley St.</u>  |  |          |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><u>George Washington</u>  |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><u>Leona Spriggs</u>  |  |   |  |  |  |          |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><u>yes</u>  |  | 16b. SOCIAL SECURITY NO.<br><u>Korean 218-26-6252</u>   |  | 17. INFORMANT<br><u>HELEN WELLS</u>  |  | ADDRESS<br><u>748 N. Grantley St.</u>   |  |  |  |          |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>metastatic carcinoma of lung</u><br>1629 DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>adenocarcinoma of R lung</u><br>DUE TO, OR AS A CONSEQUENCE OF (c) <u>1 yr.</u><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>4 months</u> |  |   |  |  |  |   |  |  |  |          |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:<br><u>bronchopneumonia</u>   |  |   |  |  |  |   |  |  |  |          |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |          |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><u>P.M. 19</u>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |   |  |  |  |          |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |   |  |  |  |          |  |
| 22a. I certify that (I) (the deceased) attended the deceased from <u>2-1</u> , 19 <u>81</u> , to <u>2-12</u> , 19 <u>82</u> , that (I) (we) lost saw the deceased alive on <u>2-11</u> , 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, and (we) (did not) view the body after death.  |  |   |  |  |  |   |  |  |  |          |  |
| 22b. SIGNATURE<br><u>Stephen R. Smith, MD</u>   |  |   |  | DEGREE<br><u>MD</u> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  |   |  | 22c. DATE SIGNED<br><u>2-12-82</u>   |  |          |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>STEPHEN R. SMITH, MD</u>  |  |   |  | 22e. ADDRESS<br><u>2000 W. BALTIMORE ST. 21223</u>   |  |   |  |  |  |          |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(CHECK ONE)<br><u>Burial</u>   |  | 23b. DATE<br><u>2/19/82</u>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Mid West Cem.</u>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><u>Brownsville 21211</u>                          |  |  |  |          |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><u>Chas H. Powell</u>   |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><u>FEB 18 1982</u>  |  | 25b. REGISTRAR'S SIGNATURE<br><u>Thane J. [Signature]</u>                                       |  |  |  |          |  |

DEPT. OF AGRICULTURE



The following is a list of the  
 names of the persons who  
 have been appointed to the  
 various positions in the  
 Department of Agriculture  
 for the year 1900.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 7 days with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

82 04331

REG. NO.

|   |  |  |  |   |  |
|---|--|--|--|---|--|
| 1. FOR STATE REGISTRAR  |  | 2a. DATE OF DEATH  |  | 2b. HOUR  |  |
| 1. DECEASED NAME (TYPE OR PRINT) <b>Helen E. WERNER</b>   |  | MONTH DAY YEAR <b>02 14 82</b>   |  | 12:45 PM  |  |
| 3. SEX <b>FEMALE</b>  | 4. RACE <b>WHITE</b>   | 5. DATE OF BIRTH   |  | 6. AGE (IN YEARS LAST BIRTHDAY)   |  |
|   |  | MONTH DAY YEAR <b>02 23 07</b>   |  | <b>74</b> YRS.  |  |
| 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>  | 7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.                    |  |
| 10. CITY OR TOWN OF DEATH <b>Baltimore MD</b>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Baltimore City Hospitals</b> | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Kitchen Helper</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY <b>Restaurant</b>                               |  |
| 13a. STATE <b>Maryland</b>  | 13b. COUNTY <b>Baltimore</b>   | 13c. CITY OR TOWN <b>Dundalk</b>   | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET ADDRESS <b>51 Waterview Road</b>                                      |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST <b>Wloczewski</b>   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Not Known</b>  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>       |  |
| 16b. SOCIAL SECURITY NO. <b>213-20-2092</b>   |  | 17. INFORMANT ADDRESS <b>1213 Hillshire Rd. Balto., MD. 21222</b>  |  | 17. NAME <b>Ann Nichols</b>   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:   |  |  |  |   |  |
| IMMEDIATE CAUSE (a) <b>cardiopulmonary arrest</b>   |  |  |  |   |  |
| DUE TO, OR AS A CONSEQUENCE OF (b) <b>intracerebral hemorrhage</b>  |  |  |  |   |  |
| DUE TO, OR AS A CONSEQUENCE OF (c) <b>metastatic squamous cell carcinoma of lung</b>  |  |  |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <b>hypertension</b>  |  |  |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |  |  |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR AM. MONTH DAY YEAR <b>P.M. 19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)    |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                    |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>4:00 AM 2-14-82</b> to <b>12:45 PM 2-14-82</b> , that (I) (we) lost <b>saw</b> the deceased alive on <b>2-14-82</b> 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death. |  |  |  |   |  |
| 22b. SIGNATURE <b>Jules C. Monier MD</b>  |  | DEGREE <b>M.D.</b> <b>intern, medical house staff</b>  |  | 22c. DATE SIGNED <b>2-14-82</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Jules C. Monier, MD</b>  |  | 22e. ADDRESS <b>Baltimore City Hospitals</b>   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>  |  | 23b. DATE <b>2/15/1982</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY <b>Green Mount</b>                             |  |
| 23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore Maryland</b>   |  | 24. FUNERAL DIRECTOR NAME <b>Duda-Ruck, Inc.</b> ADDRESS <b>7922 Wise Avenue Dundalk, MD. 21222</b>  |  |   |  |
| 25a. DATE REC'D. BY REGISTRAR <b>FEB 16 1982</b>  |  | 25b. REGISTRAR'S SIGNATURE <b>Anna J. [Signature]</b>  |  |   |  |

MEDICAL CERTIFICATION



RECEIVED  
MAY 17 1964

HERIT NOTED 2600

1964 11 18 31

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A15 ME (1))  
15M 2/80

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |  |         |   |                  |                   |  |  |                         |   | REG. NO. 04332                               |  |
|--|--|---------|---|------------------|-------------------|--|--|-------------------------|---|--|--|
| 1. FOR STATE REGISTRAR   |  |         | 1. DECEASED NAME (TYPE OR PRINT)                            |                  | FIRST MIDDLE LAST |  |  | 2a. DATE KNOWN OF DEATH |   | 2b. HOUR                                     |  |
|  |  |         | Pamela Sue Wetzel   |                  |                   |  |  | XX MONTH DAY YEAR       |   | M  |  |
| 3. SEX   |  | 4. RACE |   | 5. DATE OF BIRTH |                   | 6. AGE (IN YEARS)  |  | IF UNDER 1 YR.          |   | 2c. DATE PRONOUNCED DEAD                     |  |
| female   |  | white   |   | Jun 8, 1956      |                   | 25 YRS.  |  |                         |   | 2 15 19 82 2:20P                             |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  |         | 7b. CITIZEN OF WHAT COUNTRY?                                |                  |                   | 8. MARRIED   |  |                         | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |  |  |
| Maryland   |  |         | U.S.A.  |                  |                   | WIDOWED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |                         | Baltimore City MD.  |  |  |
| 10. CITY OR TOWN OF DEATH  |  |         | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION    |                  |                   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |  |                         | 12b. KIND OF BUSINESS OR INDUSTRY                                   |  |  |
| Baltimore  |  |         | University Hospital   |                  |                   | Child Care   |  |                         | Nursery   |  |  |
| 13a. STATE   |  |         | 13b. CITY OR TOWN   |                  |                   | 13c. INSIDE CITY LIMITS?   |  |                         | 13d. STREET ADDRESS   |  |  |
| Maryland   |  |         | Frederick   |                  |                   | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |                         | 211 North Maple Avenue  |  |  |
| 14. FATHER'S NAME  |  |         | 15. MOTHER'S MAIDEN NAME                                    |                  |                   |  |  |                         |   |  |  |
| Mehrlé L. Hobbs, Sr.   |  |         | Clara Handley   |                  |                   |  |  |                         |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)   |  |         | 16b. SOCIAL SECURITY NO.                                    |                  |                   | 17. INFORMANT  |  |                         | ADDRESS   |  |  |
| No   |  |         | None  |                  |                   | 212-62-4552  |  |                         | Mrs. Mehrlé L. Hobbs, Sr., Pike, Mt. Airy, Md.                      |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |  |         |   |                  |                   |  |  |                         |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART I DEATH WAS CAUSED BY:  |  |         |   |                  |                   |  |  |                         |   |  |  |
| IMMEDIATE CAUSE (a) Multiple injuries  |  |         |   |                  |                   |  |  |                         |   |  |  |
| 8690   |  |         |   |                  |                   |  |  |                         |   |  |  |
| CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a) STATING THE UNDERLYING CAUSE LAST.  |  |         |   |                  |                   |  |  |                         |   |  |  |
| (b)  |  |         |   |                  |                   |  |  |                         |   |  |  |
| DUE TO, OR AS A CONSEQUENCE OF   |  |         |   |                  |                   |  |  |                         |   |  |  |
| (c)  |  |         |   |                  |                   |  |  |                         |   |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).  |  |         |   |                  |                   |  |  |                         |   |  |  |
| 19a. DATE OF OPERATION   |  |         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?           |                  |                   |  |  |                         | 20. AUTOPSY?  |  |  |
|  |  |         |   |                  |                   |  |  |                         | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  |         | 21b. TIME OF INJURY   |                  |                   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)  |  |                         |   |  |  |
|  |  |         | 9:40PM 2/15 1982  |                  |                   | struck by moving vehicle   |  |                         |   |  |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>  |  |         | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) |                  |                   | 21f. LOCATION  |  |                         |   |  |  |
|  |  |         | roadway   |                  |                   | RT 27-1/2 Mi north of Main St, Mt Airy, Carroll Co, MD   |  |                         |   |  |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/> |  |         |   |                  |                   |  |  |                         |   |  |  |
| ACTUAL SIGNATURE   |  |         |   |                  |                   | TITLE (SPECIFY)  |  |                         | DATE SIGNED   |  |  |
| Hormez R. Guard, M.D.  |  |         |   |                  |                   | M.D. Assistant   |  |                         | 2/16/82   |  |  |
| EXAMINER'S NAME (TYPE OR PRINT)  |  |         | ADDRESS   |                  |                   |  |  |                         |   |  |  |
| Hormez R. Guard, M.D.  |  |         | 111 Penn Street, Balto., MD 21201                           |                  |                   |  |  |                         |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  |         | 23b. DATE   |                  |                   | 23c. NAME OF CEMETERY OR CREMATORY   |  |                         | 23d. LOCATION   |  |  |
| Burial   |  |         | Feb. 18, 1982   |                  |                   | Resthaven Memorial Gardens   |  |                         | Frederick, Frederick, Md.   |  |  |
| 24. FUNERAL DIRECTOR   |  |         | 25a. DATE REC'D. BY REGISTRAR                               |                  |                   | 25b. REGISTRAR'S SIGNATURE   |  |                         |   |  |  |
| Smith, Padeley, Keeney, Bassford Funeral Home  |  |         | FEB 22 1982   |                  |                   |  |  |                         |   |  |  |
| 106 East Church St., Frederick, Md. 21701  |  |         |   |                  |                   |  |  |                         |   |  |  |

June 1, 1953

entry

1.1

X

1953 entry

entry

entry

entry

entry

X

1953 entry

entry

1.1

entry

entry

entry

entry

1953-1954

entry

1953-1954

entry

1953-1954

entry

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 4 3 3 3

FOR  
1- STATE REGISTRAR *Nannie*

REG. NO.

|  |  |   |  |   |  |   |  |  |  |
|--|--|---|--|---|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><i>Nannie White</i>   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><i>02 26 82</i>                 |   |  | 2b. HOUR<br><i>1:10 P.M.</i>  |  |  |  |
| 3. SEX<br><i>Female</i>  |  | 4. RACE<br><i>Col.</i>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><i>3-3-1887</i>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><i>95</i>  |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.   |  |
| 7a. BIRTHPLACE<br>(COUNTRY)<br><i>Edgefield S.C.</i>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><i>U.S.A.</i>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><i>Baltimore City</i> MD.                               |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><i>Baltimore</i>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><i>Provident Hosp.</i> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><i>Housewife</i>            |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13. STATE<br><i>Maryland</i>   |  |   |  | 13b. COUNTY<br><i>BALTO.</i>  |  | 13c. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13d. STREET ADDRESS<br><i>1612 Vincent Court</i>   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><i>Scin White</i>  |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><i>Sylvia White</i>  |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><i>No</i>  |  |   |  | 16b. SOCIAL SECURITY NO.<br><i>218-76-9791</i>  |  | 17. INFORMANT<br>ADDRESS<br><i>Mrs. Mary Williams 1612 Vincent Ct</i>                           |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <i>Cardiac Arrest</i><br><i>4275</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <i>Respiratory arrest</i><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) |  |   |  |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |   |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>2-26</i> , 19 <i>82</i> , to <i>2-26</i> , 19 <i>82</i> , that (I) (we) lost saw the deceased alive on <i>2-26</i> , 19 <i>82</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                 |  |   |  |   |  |   |  |  |  |
| 22b. SIGNATURE<br><i>A. Bell M.D.</i>  |  |   |  | DEGREE  |  |   |  | 22c. DATE SIGNED<br><i>2-26-82</i>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><i>D. Bell M.D.</i>   |  |   |  | 22e. ADDRESS  |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><i>Burial</i>  |  |   | 23b. DATE<br><i>3-2-82</i>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><i>Maryland Nat'l Cem.</i>               |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><i>Prince George's Co. Md.</i> |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><i>Joseph L. Russ</i>  |  |   |  | ADDRESS<br><i>2222 W. North Ave.</i>  |  | 25a. DATE REC'D. BY REGISTRAR<br><i>MAR 5 1982</i>  |  | 25b. REGISTRAR'S SIGNATURE<br><i>Frances Jan Warren</i>  |  |

April 3-2-82 Maryland Nat. Hist. Survey  
1982-1983

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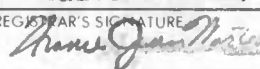
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  |   |  |   |  |  |  | REG. NO. |  |
|---|--|--|--|---|--|---|--|--|--|----------|--|
| 1. FOR STATE REGISTRAR  |  |  |  |   |  |   |  |  |  |          |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br>WALTER WILLIAM WHITE   |  |  |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>FEB. 10 82  |  | 2b. HOUR<br>12:45P <sup>M</sup>  |  |          |  |
| 3. SEX<br>MALE  |  | 4. RACE<br>BLACK   |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>4 2 25   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>56 YRS   |  | 7. IF UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 24 HRS. HOURS MIN.  |  |          |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MARYLAND   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD                                       |  |  |  |          |  |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>VAMC, LOCH RAVEN BALTO. MD. |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>HOME IMPROVEMENT            |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |          |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>MARYLAND  |  |  |  | 13b. COUNTY<br>BALTIMORE  |  | 13c. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13d. STREET ADDRESS<br>1712 BRADISH AVE. BALTO. MD   |  |          |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>Nace White   |  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Drucilla Carpenter  |  |   |  |  |  |          |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>YES   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>WWII  |  | 17. INFORMANT ADDRESS<br>vanc, LOCH RAVEN RECORDS   |  |   |  |  |  |          |  |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Respiratory Arrest</u><br>1509<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <u>Pneumonia</u><br>(c) <u>Tracheoesophageal fistula</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>10 minute<br>2 weeks<br>2 weeks |  |  |  |   |  |   |  |  |  |          |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><u>Esophageal Carcinoma</u>  |  |  |  |   |  |   |  |  |  |          |  |
| 19a. DATE OF OPERATION<br>2-8-82  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br>ESOPHAGEAL CARCINOMA   |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |          |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)<br>N.A.  |  |   |  |  |  |          |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |  |  |          |  |
| 22a. I certify that (x) (this hospital) attended the deceased from JANUARY 12, 1982, to FEBRUARY 10, 1982, that (x) (we) last saw the deceased alive on FEBRUARY 10, 1982, and that in (x) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (we) did not view the body after death.  |  |  |  |   |  |   |  |  |  |          |  |
| 22b. SIGNATURE<br>   |  |  |  | DEGREE  |  |   |  | 22c. DATE SIGNED   |  |          |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>T. FULBRIGHT   |  |  |  | 22e. ADDRESS<br>3900 LOCH RAVEN BLVD. BALTO. MD 21218   |  |   |  |  |  |          |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial   |  | 23b. DATE<br>Feb. 15-82  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Eastern Chapel Chr. Cem.  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Lusby Calvert Md.                                 |  |  |  |          |  |
| 24. FUNERAL DIRECTOR NAME<br>Spencer E. Sewell  |  |  |  | ADDRESS<br>Box 31, Prince Frederick, Md   |  | 25a. DATE REC'D. BY REGISTRAR<br>FEB 17 1982  |  | 25b. REGISTRAR'S SIGNATURE<br>        |  |          |  |



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death and may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH-16 50M 1/81  
(VRA 15, 4)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 4 3 3 5

|   |  |  |  |
|---|--|--|--|
| 1. FOR STATE REGISTRAR  |  | REG. NO.   |  |
| 1. DECEASED NAME (TYPE OR PRINT)  |  | 2a. DATE OF DEATH  |  |
| VIRGINIA H. WHITRIDGE   |  | FEBRUARY 24, 1982  |  |
| 3. SEX  |  | 2b. HOUR   |  |
| Female  |  | 8:45A M  |  |
| 4. RACE   |  | 6. AGE (IN YEARS LAST BIRTHDAY)                                |  |
| White   |  | 67 YRS.  |  |
| 5. DATE OF BIRTH  |  | 8. IF UNDER 1 YEAR   |  |
| Nov. 9, 1914  |  | MONTHS DAYS HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                           |  |
| New York  |  | Baltimore City MD  |  |
| 7b. CITIZEN OF WHAT COUNTRY?  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |  |
| USA   |  | Homemaker  |  |
| 10. CITY OR TOWN OF DEATH   |  | 12b. KIND OF BUSINESS OR INDUSTRY                              |  |
| Baltimore   |  | Own Home   |  |
| 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)  |  | 13a. STATE   |  |
| Church Hospital   |  | Maryland   |  |
| 13b. COUNTY   |  | 13c. CITY OR TOWN  |  |
|   |  | Baltimore  |  |
| 13d. INSIDE CITY LIMITS?  |  | 13e. STREET ADDRESS  |  |
| YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 1003 Poplar Hill Road  |  |
| 14. FATHER'S NAME   |  | 15. MOTHER'S MAIDEN NAME                                       |  |
| John Triplett Harrison  |  | Gertrude Leverich  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)   |  | 16b. SOCIAL SECURITY NO.                                       |  |
| No  |  | 082 22 7846  |  |
| 17. INFORMANT   |  | ADDRESS  |  |
| Dr. John Whitridge, Jr.   |  | Same   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |  |  |  |
| PART I. DEATH WAS CAUSED BY:  |  |  |  |
| IMMEDIATE CAUSE (a) ADVANCED ADENOCARCINOMA OF STOMACH  |  |  |  |
| 1519 DUE TO, OR AS A CONSEQUENCE OF DEBILITY & SEVERE VOMITING  |  |  |  |
| (b) DUE TO, OR AS A CONSEQUENCE OF  |  |  |  |
| (c)   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)  |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED               |  |
|   |  |  |  |
| 20a. AUTOPSY?   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |  |
| YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | YES <input type="checkbox"/> NO <input type="checkbox"/>       |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY  |  |
|   |  | HOUR A.M. MONTH DAY YEAR                                       |  |
|   |  | P.M. 19  |  |
| 21d. INJURY OCCURRED  |  | 21e. PLACE OF INJURY   |  |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                 |  |
|   |  | 21f. LOCATION  |  |
|   |  | STREET CITY OR TOWN COUNTY STATE                               |  |
| 22a. I certify that (I) (this hospital) attended the deceased from FEBRUARY 4, 1982, to FEBRUARY 24, 1982, that (I) (we) last saw the deceased alive on FEBRUARY 24, 1982, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death. |  |  |  |
| 22b. SIGNATURE  |  | DEGREE   |  |
| Gopal Guruswamy   |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  | 22e. ADDRESS   |  |
| GOPAL GURUSWAMY   |  | CHURCH HOSPITAL CORPORATION                                    |  |
|   |  | 100 N. BROADWAY, BALTIMORE, MD 21231                           |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |  | 23b. DATE  |  |
| Cremation   |  | 2/25/82  |  |
| 23c. NAME OF CEMETERY OR CREMATORY  |  | 23d. LOCATION  |  |
| Green Mount   |  | City or Town County State                                      |  |
|   |  | Balto., Md.  |  |
| 24. FUNERAL DIRECTOR NAME   |  | 25a. DATE OF DEATH   |  |
| Henry W. Jenkins & Sons Co.   |  | FEB 25 1982  |  |
| 4905 York Road Balto., Md. 21212  |  | REGISTRAR'S SIGNATURE  |  |
|   |  | [Signature]  |  |

MEDICAL CERTIFICATION

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California City

U.S.

New York

Flower View

Church Hospital

California

1000 Colton Hill Road

California

Maryland

Lawrence

Carroll

Franklin

Trinity

John

Box 25, John W. White, Jr.

40



Green Mount

Green Mount

John W. White, Jr.

Box 25, John W. White, Jr.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the death certificate with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |   |   |   |  | REG. NO.   |  |
|--|---|---|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>SYLVIA WIENER   |   |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>FEBRUARY 14 1982                           |  | 2b. HOUR<br>5:15A M                                |  |
| 3. SEX<br>FEMALE   | 4. RACE<br>WHITE  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>FEB. 25, 1909   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>72 YRS.  |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.       |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>NEW JERSEY  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.                        |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>JOHNS HOPKINS HOSPITAL |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>SELF-EMPLOYED |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>POET-AUTHORES |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE NEW JERSEY 13b. CITY OR TOWN LAKEWOOD   |   | 13c. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  | 13d. STREET ADDRESS<br>1155-B ARGYLE CIR.   |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>HYMAN LERNER   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>RECECCA HITTNER  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) NO  |   | 16b. SOCIAL SECURITY NO.<br>130-32-5291   |   | 17. INFORMANT<br>MRS. PATRICIA RAPPAPORT<br>11 DIANAS CIR. ROSLYN, NY 11576          |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) CARDIORESPIRATORY ARREST<br>2250<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) FRONTAL BRAIN VENOUS THROMBOSIS<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) |   |   |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |
| 19a. DATE OF OPERATION<br>1/22/82  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br>BRAIN MENINGIOMA  |   | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |  |
| 22a. I certify that (1) this hospital attended the deceased from 1/11/82 to 2/14/82, that (1) we last saw the deceased alive on 2/14/82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we (did) did not view the body after death.  |   |   |   |  |  |  |
| 22b. SIGNATURE<br>Samuel Hassenbusch MD  |   | 22c. DATE SIGNED<br>2/14/82   |   |  |  | 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>SAMUEL HASSENBUSCH MD   |
| 22e. ADDRESS<br>Johns Hopkins Hospital   |   | 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>CREMATION  |   |  |  |  |
| 23b. DATE<br>FEB. 15, 1982   |   | 23c. NAME OF CEMETERY OR CREMATORY<br>LOUDEN PARK   |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>BALTIMORE MARYLAND                     |  |  |
| 24. FUNERAL DIRECTOR<br>SOL LEVINSON & BROS., INC.<br>NAME 6010 REISTERSTOWN RD. ADDRESS BALTO., MD 21215  |   |   |   | 25a. DATE REC'D. BY REGISTRAR<br>FEB 17 1982   |  |  |

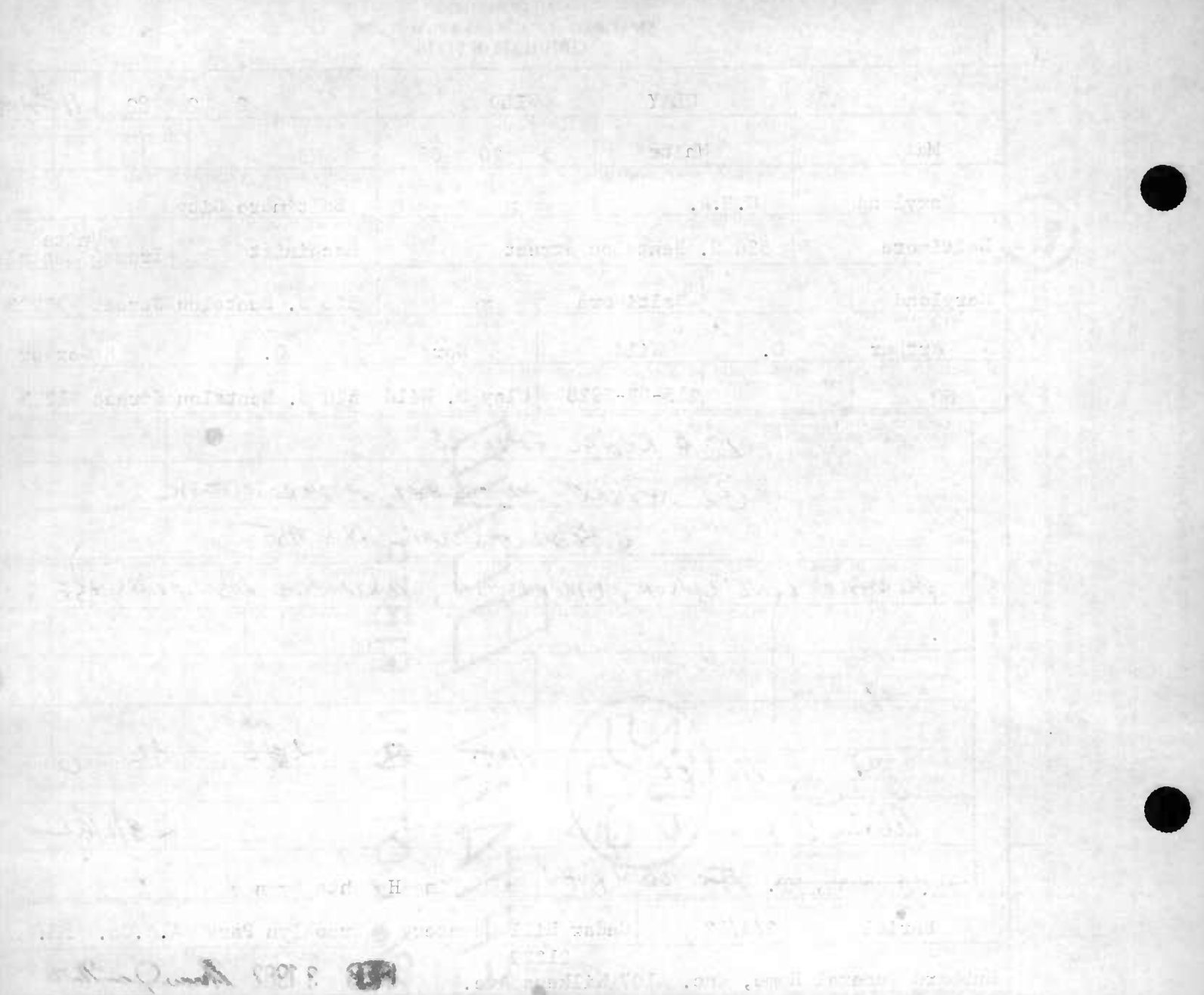
FEB 13 1966

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified on page 4.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  |   |  |   |  |  |   | REG. NO. 8 2 0 4 3 3 7   |   |   |  |
|--|--|---|--|---|--|---|--|--|---|--|---|---|--|
| 1. FOR STATE REGISTRAR   |  |   |  |   |  |   |  |  |   |  |   |   |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br>ASA CLAY WILD   |  |   |  |   | 2a. DATE OF DEATH MONTH DAY YEAR<br>2 2 82                             |   |  |  |   | 2b. HOUR<br>11:30 AM   |   |   |  |
| 3. SEX<br>Male   |  | 4. RACE<br>White  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>5 20 06   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>75 YRS.                |  |  | IF UNDER 1 YEAR<br>MONTHS DAYS  |  | IF UNDER 74 HRS.<br>HOURS MIN.                      |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD |  |  |   |  |   |   |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>520 S. Bentalou Street |  |   |  |   |  |  |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Machinist  |   | 12b. KIND OF BUSINESS OR INDUSTRY<br>United Iron & Mental |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>Maryland   |  |   |  |   | 13b. COUNTY  |   | 13c. CITY OR TOWN<br>Baltimore                                     |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br>520 S. Bentalou Street 21223 |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Arthur C. Wild   |  |   |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Dora C. Gerber        |   |  |  |   |  |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) NO  |  |   |  |   | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>215-03-5928 |   | 17. INFORMANT ADDRESS<br>Clay D. Wild 520 S. Bentalou Street 21223 |  |   |  |   |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) 5860 (b) <del>SEVERE ARTERIO-SCLEROTIC</del> (c) <del>CARDIOVASCULAR DISEASE</del><br>DUE TO, OR AS A CONSEQUENCE OF (b) <del>SEVERE ARTERIO-SCLEROTIC</del><br>DUE TO, OR AS A CONSEQUENCE OF (c) <del>CARDIOVASCULAR DISEASE</del> |  |   |  |   |  |   |  |  |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH              |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).<br>PROBABLE LUNG CANCER, EMPHYSEMA, PERIPHERAL VASCULAR DISEASE  |  |   |  |   |  |   |  |  |   |  |   |   |  |
| 19a. DATE OF OPERATION   |  |   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>      |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART I OR PART 2) |   |  |   |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  |   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  |   |  | 21f. LOCATION<br>STREET CITY COUNTY STATE                                      |   |  |   |   |  |
| 22a. I certify that (1) (this hospital) attended the deceased from 1/19/82 to 2/2/82, that (1) (we) lost saw the deceased alive on 1/29/82, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (If we) (did) (did not) view the body after death.  |  |   |  |   |  |   |  |  |   |  |   |   |  |
| 22b. SIGNATURE<br>Alvin O. Kuhn MD   |  |   |  |   |  |   |  | DEGREE   |   | 22c. DATE SIGNED<br>2/2/82   |   |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Alvin Kuhn, MD. ALVIN KUHN  |  |   |  |   |  |   |  | 22e. ADDRESS<br>1001 Pine Heights Avenue                                       |   |  |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial  |  |   |  | 23b. DATE<br>2/5/82   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Cedar Hill Cemetery |  |  |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Brooklyn Park A.A.Co. Md.  |   |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Hubbard Funeral Home, Inc. 4107 Wilkens Ave.   |  |   |  |   |  |   |  | 21229  |   | 25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE<br>FEB 3 1982 Thomas J. North                                     |   |   |  |





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 4 3 3 8

REG. NO.

|   |   |   |   |   |  |
|---|---|---|---|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br><b>MILTON F. JR. WILKINS</b>   |   |   | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>FEB. 5 82</b>  |   | 2b. HOUR<br><b>12:45P M</b>  |
| 3. SEX<br><b>MALE</b>   | 4. RACE<br><b>BLACK</b>   | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>9- 10 29</b>  | 6. AGE (IN YEARS LAST BIRTHDAY) YRS.<br><b>53</b>   | IF UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 24 HRS HOURS MIN  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>BALTIMORE, MD</b>   | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY MD</b>  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF IN SUGGESTED FACILITY, GIVE STREET ADDRESS)<br><b>VAMC, LOCH RAVEN BLVD. BALTO. MD</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)  |   | 12b. KIND OF BUSINESS OR INDUSTRY  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE COUNTY<br><b>MARYLAND BALTIMORE</b>  | 13b. CITY OR TOWN<br><b>BALTIMORE</b>   | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  | 13e. STREET ADDRESS<br><b>644 E. 29th Street 21218</b>  |   |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>MILTON F. SR. WILKINS</b>   | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>MAMIE KEENE</b>  |   |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (IF YES, GIVE WAR OR DATES)<br><b>YES</b>  | 16b. SOCIAL SECURITY NO.<br><b>KOREAN CON. 216 20 6945</b>  | 17. INFORMANT ADDRESS<br><b>VAMC, RECORDS LOCH RAVEN BLVD. BALTO. MD.</b>   |   |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardio respiratory arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>hepatic failure</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>renal failure</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br><b>5728</b>   |   |   |   |   | APPROXIMATE INTERVAL BETWEEN DEATH AND DEATH<br><b>1 month</b><br><b>2 weeks</b> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>Alcoholism, Ascites, Jaundice, Coagulopathy, Sepsis</b>   |   |   |   |   |  |
| 19a. DATE OF OPERATION<br><b>1/29/82</b>  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>Peritoneal dialysis catheter placed</b>  | 20a. AUTOPSY YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)   | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |   |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK   | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |   |   |  |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>JANUARY 5, 19 82</b> , to <b>FEBRUARY 5, 19 82</b> , that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on <b>FEBRUARY 5, 19 82</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) <input checked="" type="checkbox"/> (not) view the body after death. |   |   |   |   |  |
| 22b. SIGNATURE<br><b>Joseph M. Reilly MD</b>  | DEGREE<br><b>MD</b>   | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>                  | 22c. DATE SIGNED<br><b>2/5/82</b>   |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>JOSEPH M. Reilly</b>  | 22e. ADDRESS<br><b>3900 LOCH RAVEN BLVD. BALTIMORE, MD. 21218</b>   |   |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  | 23b. DATE<br><b>2/10/82</b>   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>MD. Veterans</b>   | 23d. LOCATION CITY OR TOWN<br><b>Crownsville</b>  | STATE<br><b>MD</b>  |  |
| 24. FUNERAL DIRECTOR NAME<br><b>Locks FUNERAL Home</b>  | ADDRESS<br><b>1304 N. Central St</b>  | 25a. DATE REC'D. BY REGISTRAR<br><b>FEB 8 1982</b>  |   | 25b. REGISTRAR'S SIGNATURE<br><b>Thom. J. [Signature]</b> |  |



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DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 4 3 3 9

1- FOR  
STATE  
REGISTRAR

REG. NO.

|   |  |  |  |   |  |  |   |  |   |  |
|---|--|--|--|---|--|--|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>REV. DR. Amanda E. Williams</b>   |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>2/11/82</b>                  |   |  | 2b. HOUR<br><b>4:35 AM</b>   |   |  |   |  |
| 3. SEX<br><b>Female</b>   |  | 4. RACE<br><b>Black</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>1 17 25</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>57</b> YRS.  |   | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.  |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>N.C.</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.  |   |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Provident Hospital</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)   |   | 12b. KIND OF BUSINESS OR INDUSTRY  |   |  |
| 13a. STATE<br><b>MD</b>   |  |  | 13b. COUNTY  |   | 13c. CITY OR TOWN<br><b>Baltimore</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>3219 Windsor Ave.</b> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Samuel Williams</b>  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Lydia Edgeton</b>  |   |  |  |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>No</b>   |  |  | 16b. SOCIAL SECURITY NO.<br><b>212-28-3873</b>                         |   | 17. INFORMANT<br>ADDRESS<br><b>Bishop Harold Williams 3219 Windsor</b>         |  |   |  |   |  |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiopulmonary Arrest</b><br>1539<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:<br>(b) <b>Colon CA E Metn.</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Colo CA E Metn.</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |  |  |   |  |  |   |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |  |  |   |  |  |   |  |   |  |
| 19a. DATE OF OPERATION  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>Feb. 2, 1982</b> to <b>Feb. 11, 1982</b> , that (I) (we) last saw the deceased alive on <b>19</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |  |  |   |  |  |   |  |   |  |
| 22b. SIGNATURE<br><b>A. L. Eley M.D.</b>  |  |  | DEGREE   |   |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |   | 22c. DATE SIGNED<br><b>Feb. 11, 82</b>   |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>E. L. Eley M.D.</b>   |  |  | 22e. ADDRESS   |   |  |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |  |  | 23b. DATE<br><b>2/16/82</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Arbutus Mem. Pk.</b>                  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Co. MD</b>                           |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Wm. C. March F/H 1101 E. North Ave.</b>  |  |  |  |   | 25a. DATE REC'D. BY REGISTRAR<br><b>FEB 16 1982</b>                            |  | 25b. REGISTRAR'S SIGNATURE<br><b>Thomas J. [Signature]</b>                                      |  |   |  |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.



Rev. Dr. G. W. P. ...

William ...

2/11/20

30

17

17

Charles ...  
Colon ...

Feb. 20 - 22 Feb 11

W. H. ...  
...

...

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after pronouncement may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| FOR STATE REGISTRAR   |  |   |  | STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  | REG. NO.   |  |
|---|--|---|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  |   |  | 2a. DATE OF DEATH   |  | 2b. HOUR   |  |
| ARTHUR D. WILLIAMS  |  |   |  | FEBRUARY 25, 1982   |  | 12:10 PM   |  |
| 3. SEX  |  | 4. RACE   |  | 5. DATE OF BIRTH  |  | 6. AGE (IN YEARS LAST BIRTHDAY)  |  |
| MALE  |  | NEGRO   |  | JAN 17 1896   |  | 86   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  | 7b. CITIZEN OF WHAT COUNTRY?  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                                     |  |
| GEORGIA   |  | U.S.A.  |  |   |  | BALTIMORE CITY MD.   |  |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| BALTIMORE   |  | ST. AGNES HOSPITAL  |  | LABORER/R.R.  |  | AMTRAX   |  |
| 13a. STATE  |  |   |  | 13b. CITY OR TOWN   |  | 13c. STREET ADDRESS  |  |
| MARYLAND  |  |   |  | BALTIMORE   |  | 1546 INGLESIDE AVE 21207   |  |
| 14. FATHER'S NAME   |  |   |  | 15. MOTHER'S MAIDEN NAME  |  |  |  |
| EARL WILLIAMS   |  |   |  | ANNA WILLIAMS   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)  |  |   |  | 16b. SOCIAL SECURITY NO.  |  | 17. VEIN MILBURN/774 LINNARD STREET<br>MILDRED TILLEY/1546 INGLESIDE AVE |  |
| YES   |  |   |  | I   |  | 717-07-6758  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |  |   |  |   |  |  |  |
| PART I. DEATH WAS CAUSED BY:  |  |   |  |   |  |  |  |
| IMMEDIATE CAUSE (a) <u>Pneumonia</u>  |  |   |  |   |  |  |  |
| 4960  |  |   |  |   |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF  |  |   |  |   |  |  |  |
| (b) <u>Chronic obstructive pulmonary disease</u>  |  |   |  |   |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF  |  |   |  |   |  |  |  |
| (c)   |  |   |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)  |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?           |  |
|   |  |   |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | YES <input type="checkbox"/> NO <input type="checkbox"/>                 |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>2-18-</u> 19 <u>82</u> , to <u>2-20</u> 19 <u>82</u> , that (I) (we) last saw the deceased alive on <u>2-24-82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |  |   |  |  |  |
| 22b. SIGNATURE<br><u>Mathew</u>   |  |   |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>        |  | 22c. DATE SIGNED<br><u>2/25/82</u>                                       |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>Mathew</u>  |  |   |  | 22e. ADDRESS<br><u>St. Agnes Hospital, Baltimore.</u>   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |  | 23b. DATE   |  | 23c. NAME OF CEMETERY OR CREMATORY  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE                               |  |
| BURIAL  |  | 03/01/82  |  | BALTO NATL CEM  |  | BALTIMORE MARYLAND   |  |
| 24. FUNERAL DIRECTOR<br>MARSHALL W JONES, JR/4101 EDMONDSON AVE   |  |   |  | 25a. DATE REC'D. BY REGISTRAR   |  | 25b. REGISTRAR'S SIGNATURE<br><u>Thom Jones</u>                          |  |
|   |  |   |  | FEB 26 1982   |  |  |  |

U. S. DEPARTMENT OF JUSTICE

NO. 17 1898

BALTIMORE CITY

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR  
1. STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |   |   |  |   |
|--|--|---|---|--|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>BEN WILLIAMS  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>FEBRUARY 18, 1982                            |  | 2b. HOUR<br>9:57A M   |
| 3. SEX<br>MALE   | 4. RACE<br>BLACK   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>8 27 1903   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>78 YRS.   | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>South Carolina  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.                          |  |   |
| 10. CITY OR TOWN OF DEATH<br>Baltimore   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Maryland General Hospital |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>RAILROAD WORKER | 12b. KIND OF BUSINESS OR INDUSTRY<br>RAILROAD  |   |
| 13a. STATE<br>Maryland   |  |   | 13b. COUNTY<br>—  | 13c. CITY OR TOWN<br>Baltimore   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                       |
| 13e. STREET ADDRESS<br>1115 Madison Ave.   |  | 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>John — Williams   |   |  |   |
| 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>MARY — HERBERT  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) NO   |   |  |   |
| 16b. SOCIAL SECURITY NO.<br>718-14-0774  |  | 17. INFORMANT<br>FAIRL CHURCH ADDRESS VIRGINIA 22041<br>Mr. W. L. DAVIS 5802 OAKVIEW GARDENS/APT 422  |   |  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Resolving Posteroseptal myocardial infarction<br>4100<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) Myocardial hypertrophy<br>(c) Arteriosclerotic Cardiovascular disease      |  |   |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br>Arteriolonephrosclerosis  |  |   |   |  |   |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)       |   |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |   |
| 22a. I certify that (I) <del>XXXXXX</del> attended the deceased from February 18, 19 82, to February 18, 19 82, that (I) <del>xx</del> lost saw the deceased alive on February 18, 19 82, and that in (my) <del>xxx</del> opinion death occurred on the date and hour and from the causes stated above, (I) <del>xxx</del> (did) <del>xxx</del> view the body after death. |  |   |   |  |   |
| 22b. SIGNATURE<br>Harry E. Nervino, M.D.   |  |   |   | 22c. DATE SIGNED<br>2/18/82  |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Harry E. Nervino, M.D.  |  |   |   | 22e. ADDRESS<br>c/o Maryland General Hospital  |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY) BURIAL  |  | 23b. DATE<br>2/23/82  |   | 23c. NAME OF CEMETERY OR CREMATORY<br>North CEMETERY                                 |   |
| 23d. LOCATION<br>CITY OR TOWN  |  | 23e. STATE<br>South Carolina  |   | 23f. COUNTY  |   |
| 24. FUNERAL DIRECTOR<br>NAME<br>Pratt, F.H., NEWBERRY South Carolina   |  |   |   | 25. DATE REC'D. BY REGISTRAR<br>FEB 22 1982  |   |
| 26. NAME<br>JAMES A. MORTON F.H. 101 LAURENS ST, SALT  |  |   |   | 27. SIGNATURE<br>Charles J. ...  |   |





DATE: FEBRUARY 1, 1962  
PATIENT: JAMES A. WILSON  
AGE: 25  
SEX: Male  
RACE: Black  
BIRTHPLACE: St. Louis, Mo.  
EDUCATION: High School  
OCCUPATION: Unemployed  
RELIGION: Catholic  
MARRIAGE: Single  
FAMILY: No children  
PAST MEDICAL HISTORY: No previous illness  
PAST SURGICAL HISTORY: No previous surgery  
PAST DRUG HISTORY: No previous drug use  
PAST ALCOHOL HISTORY: No previous alcohol use  
PAST TOBACCO HISTORY: No previous tobacco use  
PAST DRUG ABUSE HISTORY: No previous drug abuse  
PAST ALCOHOL ABUSE HISTORY: No previous alcohol abuse  
PAST TOBACCO ABUSE HISTORY: No previous tobacco abuse  
PAST DRUG ABUSE HISTORY: No previous drug abuse  
PAST ALCOHOL ABUSE HISTORY: No previous alcohol abuse  
PAST TOBACCO ABUSE HISTORY: No previous tobacco abuse

Presenting Complaint: Chest pain, shortness of breath, and fatigue.  
History of Present Illness: The patient reports a 2-week history of chest pain, shortness of breath, and fatigue. The pain is described as a heavy, crushing sensation in the center of the chest, which is worse with exertion and at rest. The shortness of breath is described as a feeling of tightness in the chest, which is worse with exertion and at rest. The fatigue is described as a general feeling of tiredness, which is worse with exertion and at rest.

Physical Examination: The patient is a 25-year-old Black male, 5'10" tall, 160 lbs. He is in good health, with no significant findings on physical examination.



Diagnosis: Myocardial infarction.

Recommendations: The patient should be treated with aspirin, nitroglycerin, and beta-blockers. He should also be advised to stop smoking and to exercise regularly.

Signature: [Illegible]  
Date: February 1, 1962  
Location: St. Louis, Mo.  
Hospital: St. Louis Hospital  
Physician: Dr. J. A. Wilson  
Nurse: [Illegible]  
Pharmacist: [Illegible]  
Dietitian: [Illegible]  
Social Worker: [Illegible]  
Counselor: [Illegible]  
Other: [Illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician or completely filled in by the funeral director, page 3 should be detached for use in the funeral home. When please name and address of the funeral home. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal with the State Dept. of Health and Mental Hygiene. **IMPORTANT:** If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

DHMH-16 30M 2/80  
(VRA 15, 4)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 4 3 4 2

1- FOR  
STATE  
REGISTRAR

REG. NO.

|   |  |   |   |  |  |
|---|--|---|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>BESSIE WILLIAMS</b>   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>February 07, 1982</b>                                 |  | 2b. HOUR<br><b>1035a</b>                     |
| 3. SEX<br><b>Female</b>   | 4. RACE<br><b>Black</b>  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>9 19 1910</b>  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>71</b><br>YRS. MONTHS DAYS HOURS MIN.          |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>NORTH CAROLINA</b>  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.                    |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>JOHNS HOPKINS HOSPITAL</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Domestic</b>             |  | 12b. KIND OF BUSINESS OR INDUSTRY            |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |   |   |  |  |
| 13a. STATE<br><b>M.D.</b>   | 13b. COUNTY  | 13c. CITY OR TOWN<br><b>BALTO.</b>  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS<br><b>11 W. 20th ST. 18 A<sup>2121P</sup></b>                    |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>UNKNOWN</b>  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>UNKNOWN</b>   |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>242-34-2707</b>  |   | 17. INFORMANT<br>ADDRESS<br><b>DORIS SCOTT 1008 Rutland Ave</b>                      |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br><b>4589</b><br>IMMEDIATE CAUSE (a) <b>HYPERKALEMIA</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>RENAL FAILURE</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>HYPOTENSION</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |   |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).<br><b>None</b>   |  |   |   |  |  |
| 19a. DATE OF OPERATION<br><b>None</b>   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)       |   |  |  |
| 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED<br>(ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |   |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>2/5</b> 19 <b>82</b> to <b>2/7</b> 19 <b>82</b> , that (I) (we) lost saw the deceased alive on <b>2/7</b> 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |   |   |  |  |
| 22b. SIGNATURE<br><b>Daniel J. Dwyer, MD.</b>   |  | DEGREE<br><b>MD.</b>  |   | 22c. DATE SIGNED<br><b>2/7/82</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>DAN DWYER</b>   |  | 22e. ADDRESS<br><b>The Johns Hopkins Hospital</b>   |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>2/12/82</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>King Mem. Park</b>                          |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>BALTIMORE</b>  |  | 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>RODD FUNERAL HOME 5209 York Rd.</b>  |   |  |  |
| 25a. DATE REC'D. BY REGISTRAR<br><b>FEB 10 1982</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Charles J. Nathan</b>  |   |  |  |

MEDICAL CERTIFICATION

2017年01月10日

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be retained by the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal, and in any event, within 72 hours after death.

## MEDICAL CERTIFICATION

|  |  |  |  |   |  |  |  |
|--|--|--|--|---|--|--|--|
| 1. DECEASED-NAME<br>(Type or print) <b>Coleman</b>   |  | First Middle Last  |  | 2a. DATE OF DEATH<br><b>2</b> Month <b>27</b> Day <b>82</b> Year  |  | 2b. HOUR<br><b>2:05 P</b>  |  |
| 3. SEX<br><b>male</b>  |  | 4. RACE<br><b>Black</b>  |  | 5. DATE OF BIRTH<br><b>12/21/03</b>   |  | 6. AGE (In years last birthday)<br><b>78</b> YRS.                          |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>md.</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | B. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br><b>Balto City</b>                                    |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>Granada Nursing Home<br/>4017 Liberty Hrs. Avenue</b> |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>Mechanic</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Self Employed</b>                  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>md.</b>  |  | 13b. COUNTY<br><b>Balto.</b>   |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 13e. STREET AND NUMBER<br><b>423 Ethland Avenue</b>                        |  |
| 14. FATHER'S NAME<br><b>Robert H Wms.</b>  |  | First Middle Last  |  | 15. MOTHER'S MAIDEN NAME<br><b>Annie Strange</b>  |  | First Middle Last  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)   |  | 16b. SOCIAL SECURITY NO.<br><b>212-07-5600</b>   |  | 17. INFORMANT<br><b>Melvin Wms.</b>   |  | Address<br><b>2210 Rosedale St.</b>  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiopulmonary Arrest</b><br><b>1629</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) <b>Ca Lung in Melantan</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) |  |  |  |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)  |  |  |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?       |  |
| 21a. ACCIDENT WAS OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)   |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)   |  |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)   |  | 21f. LOCATION<br>Street or R.F.D. No. City or Town County State   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>12-22, 1981</b> , to <b>2-27, 1982</b> , that (I) (we) last saw the deceased alive on <b>2-27-1982</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |  |  |   |  |  |  |
| 22b. SIGNATURE<br><b>MD</b>  |  |  |  | 22c. DATE SIGNED<br><b>2-27-82</b>  |  |  |  |
| 22d. PHYSICIAN'S NAME (Type)<br><b>NAIR</b>  |  |  |  | 22e. ADDRESS<br><b>Solo York Road BALTIMORE</b>   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL <b>REMOVAL</b>   |  | 23b. DATE<br><b>3-3-82</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>MT. CALVARY</b>  |  | 23d. LOCATION (City or Town) (County) (State)<br><b>BALTIMORE MARYLAND</b> |  |
| 24. FUNERAL DIRECTOR<br><b>E.L. PHILLIPS</b>   |  |  |  | ADDRESS<br><b>1721 N. MONROE ST.</b>  |  | 25a. REC'D BY REGISTRAR<br>DATE <b>MAR 4 1982</b>                          |  |
|  |  |  |  | 25b. REGISTRAR'S SIGNATURE<br><b>James J. Nathan</b>  |  |  |  |

13065 COLTON 11 19

WILLIAM



1 - FOR  
STATE  
REGISTRAR

REG. NO.

|   |   |   |          |  |            |  |                                   |  |                 |
|---|---|---|----------|--|------------|--|-----------------------------------|--|-----------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |   | FIRST   | MIDDLE   | LAST   | REG. NO.   | MONTH  | DAY                               | YEAR   | 2b. HOUR        |
| John  |   | Richard   | Williams |  | Feb 2 1982 |  |                                   |  | 6 <sup>00</sup> |
| 3. SEX  | 4. RACE   | 5. DATE OF BIRTH  |          | 6. AGE (IN YEARS LAST BIRTHDAY)  |            | 7a. MONTH  |                                   | 7b. DAY  |                 |
| Male  | White   | 1893<br>3 18 1893   |          | 88   |            |  |                                   |  |                 |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)  | 7b. CITIZEN OF WHAT COUNTRY?  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |          | 9. BALTIMORE CITY OR COUNTY OF DEATH   |            |  |                                   |  |                 |
| Maryland  | U.S.A.  |   |          | Baltimore City   |            |  |                                   |  |                 |
| 10. CITY OR TOWN OF DEATH   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |   |          | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)               |            |  | 12b. KIND OF BUSINESS OR INDUSTRY |  |                 |
| Baltimore   | 4603 Schenley Rd 21210  |   |          | Policeman  |            |  | Balto City                        |  |                 |
| 13a. STATE  |   | 13b. COUNTY   |          | 13c. CITY OR TOWN  |            | 13d. STREET ADDRESS                                      |                                   |  |                 |
| Maryland  |   | -----   |          | Baltimore  |            | 4603 Schenley Rd 21210                                   |                                   |  |                 |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST  |   |   |          | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST                                  |            |  |                                   |  |                 |
| John Thomas Williams  |   |   |          | Virginia Trice   |            |  |                                   |  |                 |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)  |   | 16b. SOCIAL SECURITY NO.  |          | 17. INFORMANT ADDRESS  |            |  |                                   |  |                 |
| Yes   |   | 220-44-2657   |          | Margaret Williams 4603 Schenley Rd 21210                                       |            |  |                                   |  |                 |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>C.S.C.V.D</u><br>4292 DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |   |   |          |  |            |  |                                   |  |                 |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a  |   |   |          |  |            |  |                                   |  |                 |
| 19a. DATE OF OPERATION  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |          |  |            | 20a. AUTOPSY?  |                                   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |                 |
|   |   |   |          |  |            | YES <input type="checkbox"/> NO <input type="checkbox"/> |                                   | YES <input type="checkbox"/> NO <input type="checkbox"/>       |                 |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |          | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |            |  |                                   |  |                 |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT HOME   |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |          | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |            |  |                                   |  |                 |
|   |   |   |          | 1950 Feb 2 82  |            |  |                                   |  |                 |
| 22a. I certify that (i) (this hospital) attended the deceased from Jan 29 1982 to Feb 2 1982, that (ii) (we) last saw the deceased alive on Jan 29 1982 and that in (my) medical opinion death occurred on the date and hour and from the causes stated   |   |   |          |  |            |  |                                   |  |                 |
| 22b. SIGNATURE<br>W. G. Helfrich M.D.<br>DEGREE ATTENDING PHYSICIAN MEDICAL DIRECTOR STAFF PHYSICIAN  |   |   |          |  |            |  |                                   | 22c. DATE SIGNED<br>2-3-82                                     |                 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>William G. Helfrich  |   |   |          |  |            |  |                                   | 22e. ADDRESS<br>5006 Roland Ave 21210                          |                 |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)  |   | 23b. DATE   |          | 23c. NAME OF CEMETERY OR CREMATORY   |            | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE               |                                   |  |                 |
| Buried  |   | 2-4-82  |          | Druid Ridge Cemetery   |            | Pikesville, Baltimore Md                                 |                                   |  |                 |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS  |   |   |          | 25. DATE REC'D. BY REGISTRAR   |            |  |                                   |  |                 |
| Mitchell-Wiedefeld Home 6500 York Rd 21212  |   |   |          | FEB 8 1982   |            |  |                                   |  |                 |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 1 should be signed by the physician who attended the patient or the physician who was first notified of the death and is retained by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

DHMH - 16 50M 1/B1  
(VRA 15, 4)



Handwritten text at the top left, possibly a date or reference number.

William

Richard

John

18 1883

1 10

White

also

William's City

W.B.

Marine

White City

William

James Schenck

William

James Schenck

William

James

William

White

William

William

Thomas

John

James Schenck and William

White

White

Handwritten text in the center, possibly a date or reference number.

Handwritten text in the lower middle section.

Handwritten text at the bottom left.

White

William

James Schenck

White

White

James Schenck



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |   |  |   |   |  |  | REG. NO. 8 2 0 4 3 4 5                       |  |
|--|--|--|--|---|--|---|---|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Lela D. Williams</b>  |  |  |  |   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>2 16 1982</b>   |   |  | 2b. HOUR<br><b>M</b>   |  |  |
| 3. SEX<br><b>female</b>  |  | 4. RACE<br><b>black</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>4 8 199</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>82</b> YRS  |   | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.  |  | IF UNDER 24 HRS.<br>HOURS MIN.               |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Ala</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore city</b> MD.                               |   |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>1810 W. Lanvale Street</b> |  |   |  |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)   |  | 12b. KIND OF BUSINESS OR INDUSTRY            |  |
| 13a. STATE<br><b>MD</b>  |  | 13b. COUNTY  |  | 13c. CITY OR TOWN<br><b>Baltimore</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   | 13e. STREET ADDRESS<br><b>1810 E. Lanvale Street</b>   |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Governor Hall</b>   |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Mollie Pouncey</b>  |  |   |   |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>  |  |  |  | 16b. SOCIAL SECURITY NO.<br><b>N/A</b>  |  | 17. INFORMANT ADDRESS<br><b>Annie L. Bee 1810 W. Lanvale Street</b>                             |   |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Myocardial Infarction</b><br><b>4100</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>colony artery sclerosis</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |  |  |   |  |   |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a)<br><b>Renal failure</b>   |  |  |  |   |  |   |   |  |  |  |  |
| 19a. DATE OF OPERATION   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>19</b>           |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |   |   |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |   |   |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>5/18</b> , 19 <b>81</b> , to <b>6/7</b> , 19 <b>81</b> , that (I) (we) last saw the deceased alive on <b>6/7/81</b> , 19 <b>81</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                            |  |  |  |   |  |   |   |  |  |  |  |
| 22b. SIGNATURE<br><b>M. R. Berman</b>  |  |  |  | DEGREE<br><b>MD</b>   |  |   |   | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br><b>2/18/82</b>           |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>M. R. Berman</b>   |  |  |  | 22e. ADDRESS<br><b>2717-HAMMONDS FERRY Rd 21227</b>   |  |   |   |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |  |  | 23b. DATE<br><b>2/22/82</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Mt Auburn Cemetery</b>                |   |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore MD</b>  |  |  |  |
| 24. FUNERAL DIRECTOR<br><b>William C. March F/H 1101 E. North Avenue</b>   |  |  |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>FEB 19 1982</b>   |   |  |  |  |  |

100-104-220-100

100-104-220-100



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial transit permit. Please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 50M 1/81  
(VRA 15, 4)

STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 4 3 4 6

REG. NO.

|   |  |   |  |   |  |   |  |   |  |                    |  |                  |  |           |  |
|---|--|---|--|---|--|---|--|---|--|--------------------|--|------------------|--|-----------|--|
| 1. FOR STATE REGISTRAR  |  | 2. DECEASED NAME (TYPE OR PRINT)  |  | 3. DATE OF DEATH  |  | 4. MONTH  |  | 5. DAY  |  | 6. YEAR            |  | 7. HOUR          |  | 8. MINUTE |  |
|   |  | Lucille E. Williams   |  | 7/9/82  |  | 7   |  | 9   |  | 82                 |  | 6:25             |  | P         |  |
| 9. SEX  |  | 10. RACE  |  | 11. DATE OF BIRTH   |  | 12. AGE   |  | 13. YEARS LAST BIRTHDAY   |  | 14. UNDER 1 YEAR   |  | 15. UNDER 24 HRS |  |           |  |
| F   |  | B   |  | 1/17/17   |  | 65  |  |   |  |                    |  |                  |  |           |  |
| 16. BIRTHPLACE (Country)  |  | 17. CITIZEN OF WHAT COUNTRY?  |  | 18. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>   |  | 19. BALTIMORE CITY OR COUNTY OF DEATH   |  |   |  |                    |  |                  |  |           |  |
| VA  |  | USA   |  | WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | Baltimore City  |  |   |  |                    |  |                  |  |           |  |
| 20. CITY OR TOWN OF DEATH   |  | 21. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (If not in a facility, give street address) |  | 22. USUAL OCCUPATION (Type of work for most of working life)                  |  | 23. KIND OF BUSINESS OR INDUSTRY  |  |   |  |                    |  |                  |  |           |  |
| Baltimore   |  | South Balt Gen Hosp   |  |   |  |   |  |   |  |                    |  |                  |  |           |  |
| 24. USUAL RESIDENCE (If nursing home or other institution, give residence before admission)   |  | 25. STATE   |  | 26. COUNTY  |  | 27. CITY OR TOWN  |  | 28. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 29. STREET ADDRESS |  |                  |  |           |  |
|   |  | MO  |  |   |  | Baltimore   |  | YES   |  | 2721 Seamon Ave.   |  |                  |  |           |  |
| 30. FATHER'S NAME   |  | 31. MOTHER'S MAIDEN NAME  |  | 32. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No or Unknown)              |  | 33. SOCIAL SECURITY NO.   |  | 34. INFORMANT   |  | 35. ADDRESS        |  |                  |  |           |  |
| Bennie  |  | Mary S. Wilson  |  | No  |  | 216-14-0616   |  | Robert Hines  |  | 2721 Seamon Ave    |  |                  |  |           |  |
| 36. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c) DUE TO, OR AS A CONSEQUENCE OF   |  | 37. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |   |  |   |  |   |  |                    |  |                  |  |           |  |
| 1519  |  | Septic Shock  |  |   |  |   |  |   |  |                    |  |                  |  |           |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.  |  | Metastatic Stomach Ca   |  |   |  |   |  |   |  |                    |  |                  |  |           |  |
| PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) (b) (c)   |  |   |  |   |  |   |  |   |  |                    |  |                  |  |           |  |
| 38. DATE OF OPERATION   |  | 39. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 40. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>         |  | 41. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>  |  |   |  |                    |  |                  |  |           |  |
| 42. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)   |  | 43. TIME OF INJURY HOUR A.M. MONTH DAY YEAR   |  | 44. HOW INJURY OCCURRED (Enter nature of injury in item 18, Part 1 or Part 2) |  |   |  |   |  |                    |  |                  |  |           |  |
|   |  | P.M. 10   |  |   |  |   |  |   |  |                    |  |                  |  |           |  |
| 45. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  | 46. PLACE OF INJURY (At home, street, factory, office, farm, etc.)                                  |  | 47. LOCATION (Street)   |  | CITY OR TOWN  |  | COUNTY  |  | STATE              |  |                  |  |           |  |
|   |  |   |  |   |  |   |  |   |  |                    |  |                  |  |           |  |
| 48. I certify that (I) (this hospital) attended the deceased from 19 to 19, that (I) (we) last saw the deceased alive on 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |  | 49. SIGNATURE   |  | DEGREE  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL STAFF <input type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/> |  | 50. DATE SIGNED   |  |                    |  |                  |  |           |  |
|   |  | Stephen Calhoun   |  | MD  |  |   |  | 2/9/82  |  |                    |  |                  |  |           |  |
| 51. PHYSICIAN'S NAME (Type or Print)  |  | 52. ADDRESS   |  |   |  |   |  |   |  |                    |  |                  |  |           |  |
| Stephen Calhoun   |  | SBGH  |  |   |  |   |  |   |  |                    |  |                  |  |           |  |
| 53. BURIAL, CREMATION, REMOVAL (Specify)  |  | 54. DATE  |  | 55. NAME OF CEMETERY OR CREMATORY   |  | 56. LOCATION (City or town)   |  | COUNTY  |  | STATE              |  |                  |  |           |  |
| Burial  |  | 2/13/82   |  | Church Cem.   |  | Cullev  |  |   |  | VA                 |  |                  |  |           |  |
| 57. FUNERAL DIRECTOR (Name)   |  | 58. ADDRESS   |  | 59. DATE REC'D. BY REGISTRAR  |  | 60. REGISTRAR'S SIGNATURE   |  |   |  |                    |  |                  |  |           |  |
| Wm. C. March F/H  |  | 1101 E. North Ave.  |  | FEB 11 1982   |  | James J. Martin   |  |   |  |                    |  |                  |  |           |  |

MEDICAL CERTIFICATION

99

BP

2542



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 4 3 4 7

1- FOR  
STATE  
REGISTRAR

REG. NO.

|   |  |  |  |   |  |   |   |   |  |
|---|--|--|--|---|--|---|---|---|--|
| 1. DECEASED'S NAME<br>(TYPE OR PRINT)<br><b>Mable Williams</b>  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>2-16-82</b>                  |   |  | 2b. HOUR<br><b>3:27 P.M.</b>  |   |   |  |
| 3. SEX<br><b>female</b>   |  | 4. RACE<br><b>black</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>3 5 1904</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>77</b> YRS.                         |   | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>N.C.</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.         |   |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Johns Hopkins Hospital</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)          |   | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| 13a. STATE<br><b>Md</b>   |  |  | 13b. COUNTY  |   | 13c. CITY OR TOWN<br><b>Baltimore</b>  |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Joe Williams</b>   |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Unknown</b>        |   |  | 1500 E. Federal Street  |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>   |  |  | 16b. SOCIAL SECURITY NO.<br><b>220-30-0684</b>                         |   | 17. INFORMANT<br>ADDRESS<br><b>Roland Griffin 1500 E. Federal Street</b>       |   |   |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>cardiac asystole</b><br>2030<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>deceleration</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>multiple myeloma</b>  |  |  |  |   |  |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>few minutes</b><br><b>2 months</b><br><b>2 months - since diagnosis was made</b> |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>none</b>  |  |  |  |   |  |   |   |   |  |
| 19a. DATE OF OPERATION  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>          |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>      |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |   |   |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |   |   |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>12/18</b> , 19 <b>81</b> , to <b>2/16</b> , 19 <b>82</b> , that (I) (we) lost saw the deceased alive on <b>2/16</b> , 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (we) (did) (did not) view the body after death. |  |  |  |   |  |   |   |   |  |
| 22b. SIGNATURE<br><b>Lw Martin MD</b>   |  |  |  |   | DEGREE   |   | 22c. DATE SIGNED<br><b>2/16/82</b>  |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Lw Martin</b>   |  |  |  |   | 22e. ADDRESS<br><b>Johns Hopkins Hospital Baltimore Md.</b>                    |   |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |  |  | 23b. DATE<br><b>2/20/82</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Baltimore Cem</b>                     |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Md.</b>                              |   |  |
| 24. FUNERAL DIRECTOR<br><b>William C. March F/H 1101 E. North Ave</b>   |  |  |  |   | 25a. DATE REC'D BY REGISTRAR<br><b>FEB 19 1982</b>                             |   |   |   |  |



RECEIVED  
JAN 11 1965

DO NOT WRITE IN THESE SPACES



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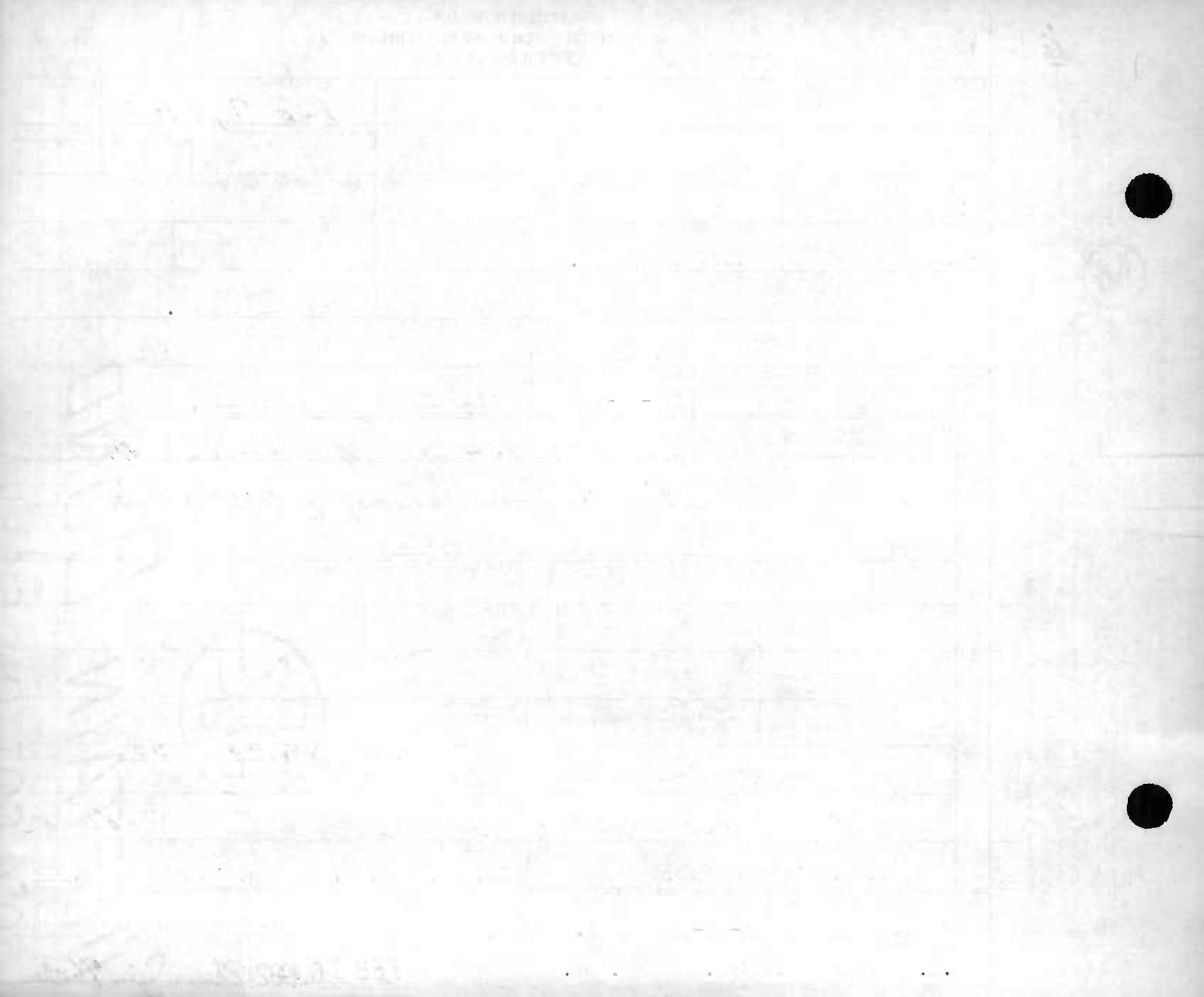
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |  |  |  |  |  |  | 8 2 0 4 3 4 8       |     |      |          |
|--|--|--|--|--|--|--|--|--|--|---------------------|-----|------|----------|
| 1. FOR STATE REGISTRAR   |  | REG. NO.   |  |  |  |  |  |  |  |                     |     |      |          |
| 1. DECEASED NAME (TYPE OR PRINT)   |  | FIRST  |  | MIDDLE   |  | LAST   |  | 2a. DATE OF DEATH                            |  | MONTH               | DAY | YEAR | 2b. HOUR |
| MAGGIE   |  | WILLIAMS   |  |  |  |  |  | Feb 7, 1982                                  |  |                     |     |      | M        |
| 3. SEX   |  | 4. RACE  |  | 5. DATE OF BIRTH   |  | 6. AGE (IN YEARS LAST BIRTHDAY)  |  | IF UNDER 1 YEAR                              |  | IF UNDER 24 HRS     |     |      |          |
| FEMALE   |  | BLACK  |  | 6 MONTH DAY YEAR 1907  |  | 74 YRS   |  | MONTHS DAYS                                  |  | HOURS MIN.          |     |      |          |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH   |  |  |  |                     |     |      |          |
| VIRGINIA   |  | US   |  |  |  | CITY   |  |  |  |                     |     | MD.  |          |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |  |  |                     |     |      |          |
| BALTIMORE  |  | 1319 LEMMON ST.  |  |  |  |  |  |  |  |                     |     |      |          |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  | 13a. STATE   |  | 13b. COUNTY  |  | 13c. CITY OR TOWN  |  | 13d. INSIDE CITY LIMITS?                     |  | 13e. STREET ADDRESS |     |      |          |
| MARYLAND   |  |  |  | BALTIMORE  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 1319 LEMMON ST.                              |  |                     |     |      |          |
| 14. FATHER'S NAME  |  | 15. MOTHER'S MAIDEN NAME   |  |  |  |  |  |  |  |                     |     |      |          |
| RICHARD  |  | WALTHALL   |  | MARY   |  | UNKNOWN  |  |  |  |                     |     |      |          |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)  |  | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)   |  | 17. INFORMANT  |  | ADDRESS  |  |  |  |                     |     |      |          |
| NO   |  | 215-18-5063  |  | MARY BROWN   |  | PORTSMITH, VIRGINIA  |  |  |  |                     |     |      |          |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:   |  | IMMEDIATE CAUSE (a)  |  | DUE TO, OR AS A CONSEQUENCE OF (b)   |  | DUE TO, OR AS A CONSEQUENCE OF (c)   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |                     |     |      |          |
| 5150   |  | Respiratory insufficiency  |  | Spontaneous pulmonary fibrosis   |  | 8 yrs  |  |  |  |                     |     |      |          |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last  |  |  |  |  |  |  |  |  |  |                     |     |      |          |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):   |  |  |  |  |  |  |  |  |  |                     |     |      |          |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?   |  |  |  |                     |     |      |          |
|  |  |  |  | YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |  |  |                     |     |      |          |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |  |  |  |                     |     |      |          |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |  |  |  |  |                     |     |      |          |
| 22a. I certify that (1) (this hospital) attended the deceased from May 1974 to Jan 20 1982, that (1) (two) last saw the deceased alive on Jan 20 1982, and that in my (one) opinion death occurred on the date and hour and from the causes stated above (1) (we did) (did not) view the body after death. |  | 22b. SIGNATURE   |  | DEGREE   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED                             |  |                     |     |      |          |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  | 22e. ADDRESS   |  |  |  |  |  | 2/10/82                                      |  |                     |     |      |          |
| A. C. Alevizatos, M.D.   |  | 301 St. Paul Place Baltimore, MD 21202   |  |  |  |  |  |  |  |                     |     |      |          |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE  |  |  |  |                     |     |      |          |
| BURIAL   |  | 2-12-82  |  | MT. ARBURN   |  | BALTIMORE MARYLAND   |  |  |  |                     |     |      |          |
| 24. FUNERAL DIRECTOR NAME  |  | 24b. ADDRESS   |  | 25a. DATE REC'D. BY REGISTRAR  |  | 25b. REGISTRAR'S SIGNATURE   |  |  |  |                     |     |      |          |
| E.L. PHILLIPS  |  | 1721 N. MONROE ST.   |  | FEB 16 1982  |  | James Jean Whitham   |  |  |  |                     |     |      |          |





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified on page 3.

FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 4 3 4 9

REG. NO.

|  |  |  |  |   |  |  |  |  |
|--|--|--|--|---|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Marvin F. Williams  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>2 14 82 |   |  | 2b. HOUR<br>M  |  |  |
| 3. SEX<br>Male   |  | 4. RACE<br>White   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>8 6 1911  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>70 YRS.                       |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Virginia  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.       |  |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Baltimore City Hospital |  |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Strip Mill |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Beth. Steel   |  |
| 13a. STATE<br>Maryland   |  |  |  | 13b. COUNTY<br>Baltimore  |  | 13c. CITY OR TOWN<br>Dundalk                                     |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Frederick K. Williams  |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Grace Williams   |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>226-14-2497   |  | 17. INFORMANT<br>ADDRESS<br>Shirley J. Williams Balto., MD. 21222   |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Coronary artery</u><br>4292 DUE TO, OR AS A CONSEQUENCE OF <u>ASVD</u><br>(b) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |  |  |  |   |  |  |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |  |  |   |  |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>      |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |  |  |   |  |  |  |  |
| 22b. SIGNATURE<br>Stanley A. Morrison, M.D.  |  |  |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                   |  | 22c. DATE SIGNED   |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Stanley A. Morrison, M.D.   |  |  |  | 22e. ADDRESS<br>11 E. Chase Street, Baltimore, MD 21202   |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial   |  | 23b. DATE<br>2/17/82   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Oak Lawn  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore Maryland |  |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br>Duda-Ruck, Inc.<br>7922 Wise Avenue Dundalk, MD. 21222   |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br>FEB 16 1982  |  | 25b. REGISTRAR'S SIGNATURE<br>Shirley J. Williams                |  |  |



W. S. D.  
C. S. D.



NOT TO



1900

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

82-04350

FOR  
1- STATE  
REGISTRAR

REG. NO.

|  |   |   |  |  |   |
|--|---|---|--|--|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>MARY W. Williams              |   |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>2 9 82                |  | 2b. HL  |
| 3. SEX<br>Female   | 4. RACE<br>BLACK  | 5. DATE OF BIRTH<br>MONTH DAY<br>09 10 82   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>94                            | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Md.                     | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>City                     |   |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE                               | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FAC. GIVE STREET ADDRESS)<br>Lutheran Hospital |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE) | 12b. KIND OF BUSINESS OR INDUSTRY   |
| 13a. STATE<br>MD   |   |   | 13b. COUNTY  | 13c. CITY OR TOWN<br>Baltimore                                   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>George T. Woods            |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Emma Taylor |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) |   | 16b. SOCIAL SECURITY NO.<br>N/A.  |  | 17. INFORMANT<br>ADDRESS<br>William L. Wood 4837 Beaufort Ave    |   |

|   |  |   |
|---|--|---|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardiopulmonary arrest</u><br>4278<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Sick sinus syndrome</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |
|---|--|---|

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

|  |  |  |   |
|--|--|--|---|
| 19a. DATE OF OPERATION   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       | 19c. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>      | 19d. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |   |
| 22a. I certify that (I) (this hospital) attended this deceased from <u>2/9/82</u> to <u>2/9/82</u> that (I) (we) last saw the deceased alive on <u>2/9/82</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |   |
| 22b. SIGNATURE<br><u>K Yaw Nyunt</u>   | DEGREE   | 22c. DATE SIGNED<br><u>2/9/82</u>  |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>K YAW NYUNT   | 22e. ADDRESS<br>LUTHERAN HOSPITAL                                      |  |   |

|   |                      |  |  |
|---|----------------------|--|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial              | 23b. DATE<br>2/16/82 | 23c. NAME OF CEMETERY OR CREMATORY<br>New Cathedral Cem. | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore MD |
| 24. FUNERAL DIRECTOR<br>NAME<br>Wm. C. March F/H 1101 E. North Ave. |                      | 25a. DATE REC'D. BY REGISTRAR<br>FEB 11 1982             | 25b. REGISTRAR'S SIGNATURE<br><u>Thane Jan Thane</u>       |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

28

RECEIVED  
JAN 10 1902  
U.S. DEPT. OF AGRICULTURE



STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 4 3 5 1

REG. NO.

|  |  |  |   |  |  |   |   |  |  |  |
|--|--|--|---|--|--|---|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>William Williams</b>  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>2-6-82</b>                          |  |  | 2b. HOUR<br><b>5<sup>20</sup> AM</b>  |   |  |  |  |
| 3 SEX<br><b>MALE</b>   |  | 4 RACE<br><b>NEGRO</b>   |   | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br><b>DEC 6, 1916</b>  |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>65</b> YRS   |   | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN   |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>GEORGIA</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>US of A</b>   |   | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.  |   |  |  |  |
| 10 CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>PROVIDENT HOSPITAL</b> |   |  |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>RETIRED</b>  |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>PAINTER</b>  |  |  |
| 13a. STATE<br><b>MARYLAND</b>  |  |  | 13b. COUNTY   |  | 13c. CITY OR TOWN<br><b>BALTIMORE</b>  |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>PALL MALL RD.<br/>4638 KIMBER ROAD</b> |  |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>WILLIAM WILLIAMS</b>   |  |  | 15 MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>BESSIE MURRAY BURLEY</b>   |  |  |   |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>  |  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>213 05 3255</b> |  | 17. INFORMANT<br>ADDRESS<br><b>MRS. HAZEL WILLIAMS 4638 PALL MALL ROAD</b>     |   |   |  |  |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>HYPOTHERMIA</b><br>2639 } DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } (b) <b>MALNUTRITION</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) |  |  |   |  |  |   |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                     |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |  |   |  |  |   |   |  |  |  |
| 19a. DATE OF OPERATION   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                              |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                    |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) |   |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)        |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |   |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>2-4-19-82</b> to <b>2-6-19-82</b> that (I) (we) last saw the deceased alive on <b>2-6-19-82</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                               |  |  |   |  |  |   |   |  |  |  |
| 22b. SIGNATURE<br><b>H. Devados</b>  |  |  | DEGREE<br><b>M.D.</b>   |  |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   |  | 22c. DATE SIGNED<br><b>2-6-82</b>                                |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>H. Devados</b>   |  |  | 22e. ADDRESS<br><b>Provident Hosp.</b>  |  |  |   |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>  |  |  | 23b. DATE<br><b>2/11/82</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>CEDAR HILL CEMETERY</b>               |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>BALTO. (AA Co.) MD.</b>                        |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>LEWIS T. GWYNN</b>  |  |  | ADDRESS<br><b>4517 PARK HEIGHTS AVENUE</b>                                    |  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>FEB 8 1982</b>  |   | 25b. REGISTRAR'S SIGNATURE<br><b>James Van Nether</b>  |  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |   |  |   |   |                                  |   |  |                       |  | 8 2 0 4 3 5 2 |     |   |          |
|---|---|--|---|---|----------------------------------|---|--|-----------------------|--|---------------|-----|---|----------|
| 1- FOR<br>STATE<br>REGISTRAR  |   | REG. NO.   |   |   |                                  |   |  |                       |  |               |     |   |          |
| 1 DECEASED NAME<br>(TYPE OR PRINT)  |   | FIRST  |   | MIDDLE  |                                  | LAST  |  | 2a DATE OF DEATH      |  | MONTH         | DAY | YEAR  | 2b. HOUR |
| Yvonne Williams   |   |  |   |   |                                  |   |  | February 2, 1982      |  |               |     |   | M        |
| 3 SEX   | 4 RACE  | 5 DATE OF BIRTH  |   | 6 AGE (IN YEARS LAST BIRTHDAY)  |                                  | IF UNDER 1 YEAR   |  | IF UNDER 24 HRS       |  |               |     |   |          |
| Female  | Black   | MONTH 3 DAY 30 YEAR 46   |   | 35  |                                  | YRS.  |  | MONTHS                |  | DAYS          |     | HOURS MIN.                                      |          |
| 7a BIRTHPLACE<br>(STATE OR FOREIGN<br>COUNTRY)  | 7b CITIZEN OF WHAT COUNTRY?   | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |   | 9 BALTIMORE CITY OR COUNTY OF DEATH   |                                  |   |  |                       |  |               |     |   |          |
| MD  | USA   |  |   | Baltimore City MD   |                                  |   |  |                       |  |               |     |   |          |
| 10 CITY OR TOWN OF DEATH  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE) |   | 12b KIND OF BUSINESS OR INDUSTRY |   |  |                       |  |               |     |   |          |
| Baltimore   | 1312 N. Montford Ave.   |  |   |   |                                  |   |  |                       |  |               |     |   |          |
| 13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |   | 13b INSIDE CITY LIMITS?  |   | 13c STREET ADDRESS  |                                  |   |  |                       |  |               |     |   |          |
| 13a STATE MD  |   | 13b COUNTY   |   | 13c CITY OR TOWN Baltimore  |                                  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 1312 N. Montford Ave. |  |               |     |   |          |
| 14 FATHER'S NAME  |   | 15 MOTHER'S MAIDEN NAME  |   |   |                                  |   |  |                       |  |               |     |   |          |
| FIRST MIDDLE LAST James H. Moore  |   | FIRST MIDDLE LAST Patsy Blount   |   |   |                                  |   |  |                       |  |               |     |   |          |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)   |   | 16b SOCIAL SECURITY NO   |   | 17 INFORMANT ADDRESS  |                                  |   |  |                       |  |               |     |   |          |
| No  |   | N/A  |   | Patsy Moore 1312 N. Montford Ave.   |                                  |   |  |                       |  |               |     |   |          |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>CARDIO RESPIRATORY ARREST</u>   |   |  |   |   |                                  |   |  |                       |  |               |     | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |          |
| 1830 DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>OVARIAN CANCER, WIDESPREAD.</u>   |   |  |   |   |                                  |   |  |                       |  |               |     |   |          |
| DUE TO, OR AS A CONSEQUENCE OF<br>(c)   |   |  |   |   |                                  |   |  |                       |  |               |     |   |          |
| PART 2 OTHER SIGNIFICANT CONDITIONS <u>CONTRIBUTING TO DEATH</u> BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)   |   |  |   |   |                                  |   |  |                       |  |               |     |   |          |
| 19a DATE OF OPERATION   |   | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a AUTOPSY?  |                                  | 20b IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?    |  |                       |  |               |     |   |          |
|   |   |  |   | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>           |                                  | YES <input type="checkbox"/> NO <input type="checkbox"/>            |  |                       |  |               |     |   |          |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 21b TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |                                  |   |  |                       |  |               |     |   |          |
| 21d INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |   | 21e PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |                                  |   |  |                       |  |               |     |   |          |
| 22a I certify that (1) (this hospital) attended the deceased from 19 82, to 2/2 19 82, that (1) (we) last saw the deceased alive on 1/28 19 82, and that in (1) (my) (our) opinion death occurred on the date and hour and from the causes stated above (1) (we) (did) (did not) view the body after death. |   | 22b SIGNATURE<br>John Fetting M.D.   |   | DEGREE  |                                  | 22c DATE SIGNED<br>2/3/82   |  |                       |  |               |     |   |          |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)  |   | 22e ADDRESS  |   |   |                                  |   |  |                       |  |               |     |   |          |
| John Fetting M.D.   |   | Johns Hopkins Oncology Center  |   |   |                                  |   |  |                       |  |               |     |   |          |
| 23a BURIAL, CREMATION, REMOVAL<br>(SPECIFY)   |   | 23b DATE   |   | 23c NAME OF CEMETERY OR CREMATORY   |                                  | 23d LOCATION<br>CITY OR TOWN COUNTY STATE                           |  |                       |  |               |     |   |          |
| Burial  |   | 2/8/82   |   | Baltimore Cemetery  |                                  | Baltimore MD  |  |                       |  |               |     |   |          |
| 24 FUNERAL DIRECTOR<br>NAME   |   | ADDRESS  |   | 25a DATE REC'D. BY REGISTRAR 25b REGISTRAR'S SIGNATURE                        |                                  |   |  |                       |  |               |     |   |          |
| Wm. C. March F/H  |   | 1101 E. North Ave.   |   | FEB 4 1982  |                                  |   |  |                       |  |               |     |   |          |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 4 3 5 3

REG. NO.

|   |  |  |   |  |  |  |   |   |  |
|---|--|--|---|--|--|--|---|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Bessie S Wilson</b>  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR <b>2 3 82</b>                              |  |  | 2b. HOUR <b>3<sup>30</sup> a.m.</b>  |   |   |  |
| 3. SEX <b>F</b>   |  | 4. RACE <b>B</b>   |   | 5. DATE OF BIRTH MONTH DAY YEAR <b>2 14 04</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY) <b>77</b> YRS.   |   | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>S. Carolina</b>  |  | 7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>   |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.                               |   |   |  |
| 10. CITY OR TOWN OF DEATH <b>Baltimore</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Bon Secours Hospital</b> |   |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                                |   | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| 13a. STATE <b>MD</b>  |  | 13b. COUNTY  |   | 13c. CITY OR TOWN <b>Baltimore</b>   |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   | 13e. STREET ADDRESS <b>2910-Ellicott Dr.</b>  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST <b>William Singletary</b>   |  |  |   | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Annie Gasque</b>   |  |  |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>   |  |  |   | 16b. SOCIAL SECURITY NO. <b>212-46-9491</b>  |  | 17. INFORMANT ADDRESS <b>Marion Jones 2832 Oakford Ave</b>                                   |   |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARDIAC Arrest</b><br><b>4140</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>Coronary heart disease</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>-</b>                                    |  |  |   |  |  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>years</b>   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>-</b>   |  |  |   |  |  |  |   |   |  |
| 19a. DATE OF OPERATION  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                            |  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>                       |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>11/26 82</b> P.M. <b>19</b> |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) |  |   |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)         |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                 |  |   |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>11/26 82</b> to <b>2/3 82</b> , that (I) (we) lost saw the deceased alive on <b>2-2 82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |   |  |  |  |   |   |  |
| 22b. SIGNATURE <b>h. [Signature]</b>  |  |  |   | DEGREE <b>MD</b>   |  |  |   | 22c. DATE SIGNED <b>2/3/82</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Manuel P. Ruiz</b>   |  |  |   | 22e. ADDRESS <b>1940 W. Balb St Balto, Md 23</b>   |  |  |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>   |  |  | 23b. DATE <b>2/8/82</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Auburn Cem.</b>                      |  | 23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore MD</b> |   |  |
| 24. FUNERAL DIRECTOR NAME <b>Wm. C. March F/H</b> ADDRESS <b>1101 E. North Ave.</b>   |  |  |   |  | 25a. DATE REC'D. BY REGISTRAR <b>FEB 5 1982</b>                                |  | 25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>               |   |  |



U.S. DEPARTMENT OF AGRICULTURE  
BUREAU OF PLANT INDUSTRY

25

U.S. DEPARTMENT OF AGRICULTURE  
BUREAU OF PLANT INDUSTRY  
WASHINGTON, D.C.  
JANUARY 1914

U.S. DEPARTMENT OF AGRICULTURE  
BUREAU OF PLANT INDUSTRY

U.S. DEPARTMENT OF AGRICULTURE  
BUREAU OF PLANT INDUSTRY

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified at once.

DHMH - 16 50M 1/81  
(VRA 15, 4)



| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  |  |  |  |  |   |  |
|---|--|---|--|--|--|--|--|---|--|
| 1. FOR STATE REGISTRAR  |  | REG. NO. 8204354  |  |  |  |  |  |   |  |
| 1. DECEASED NAME (TYPE OR PRINT)  |  | FIRST MARIAN  |  | MIDDLE H   |  | LAST WILSON  |  | 2a. DATE OF DEATH MONTH DAY YEAR 2b. HOUR   |  |
| 3. SEX FEMALE   |  | 4. RACE BLACK   |  | 5. DATE OF BIRTH MONTH DAY YEAR 02 12 05   |  | 6. AGE (IN YEARS LAST BIRTHDAY) 79 YRS   |  | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) South Carolina  |  | 7b. CITIZEN OF WHAT COUNTRY? USA  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.                                      |  |   |  |
| 10. CITY OR TOWN OF DEATH BALTIMORE   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) UMH  |  |  |  | 12a. USUAL OCCUPATION (WORK FOR MOST OF WORKING TIME) Housewife                              |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| 13a. STATE MARYLAND   |  | 13b. COUNTY   |  | 13c. CITY OR TOWN BALTIMORE  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |   |  |
| 14. FATHER'S NAME FIRST MOMPARD MIDDLE Hombright LAST   |  | 15. MOTHER'S MAIDEN NAME FIRST Mary MIDDLE Jones LAST Cheeks  |  | 16. STREET ADDRESS 6115 CHARLES ST 1027 Wicklow Rd   |  |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR NO) (IF YES, GIVE WAR OR DATES) No   |  | 16b. SOCIAL SECURITY NO 182-16-2989   |  | 17. INFORMANT ADDRESS James Scalco - Deposie N.C.  |  |  |  |   |  |
| 18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIAC ARREST 5860   |  |   |  |  |  |  |  |   |  |
| DUE TO, OR AS A CONSEQUENCE OF (b) RESPIRATORY ARREST   |  |   |  |  |  |  |  |   |  |
| DUE TO, OR AS A CONSEQUENCE OF (c) Refractory renal failure and congestive failure  |  |   |  |  |  |  |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Lifelong hypertension  |  |   |  |  |  |  |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>                       |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |  |  |   |  |
| 22a. I certify that (1) (this hospital) attended the deceased from February 7, 19 82, to February 19, 19 82, that (1) (we) last saw the deceased alive on February 19, 19 82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (1) (we) (did not) view the body after death. |  |   |  |  |  |  |  |   |  |
| 22b. SIGNATURE Frank R. Claudy MD   |  | DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  |  |  | 22c. DATE SIGNED 2/19/82   |  |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Frank R. Claudy   |  | 22e. ADDRESS Dept. of Family Practice, U. of Md   |  |  |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL   |  | 23b. DATE 2/23/82   |  | 23c. NAME OF CEMETERY OR CREMATORY Westview Mem PK   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE Catonsville Balto. Md                                |  |   |  |
| 24. FUNERAL DIRECTOR Gurnell B. Oden - Balto. Md.   |  | ADDRESS   |  | 25a. DATE REC'D. BY REGISTRAR FEB 22 1982  |  | 25b. REGISTRAR'S SIGNATURE   |  |   |  |

2844 BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed with the physician's signature and the death certificate be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and the death certificate must be signed by the medical examiner.

BP

DHMM - 16 50M 1/81  
(VRA 15, 4)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 4 3 5 5

|   |  |  |  |
|---|--|--|--|
| 1. FOR STATE REGISTRAR  |  | REG. NO.   |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  | 2a. DATE OF DEATH  |  |
| Thomas Wilson   |  | 2-25-82  |  |
| 3. SEX  |  | 2b. HOUR   |  |
| Male  |  | 5:50P  |  |
| 4. RACE   |  | 6. AGE (IN YEARS LAST BIRTHDAY)  |  |
| White   |  | 65   |  |
| 5. DATE OF BIRTH  |  | IF UNDER 1 YEAR  |  |
| Nov. 3, 1916  |  | MONTHS DAYS  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  | 7b. CITIZEN OF WHAT COUNTRY?   |  |
| Va.   |  | U.S.A.   |  |
| 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH   |  |
|   |  | Baltimore City   |  |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION                        |  |
| Baltimore   |  | John Hopkins Hospital  |  |
| 12a. USUAL OCCUPATION   |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| Elec. Eng. Ret.   |  | U.S. Gov.  |  |
| 13a. STATE  |  | 13b. CITY OR TOWN  |  |
| Md.   |  | St. Mary's White Point   |  |
| 14. FATHER'S NAME   |  | 15. MOTHER'S MAIDEN NAME   |  |
| Thomas Pym. Wilson, Sr.   |  | Marjorie Whitfield   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)   |  | 16b. SOCIAL SECURITY NO.   |  |
| No  |  | 224-18-8241  |  |
| 17. INFORMANT   |  | ADDRESS  |  |
| A Betty D. Wilson   |  | Rt. 1, Box 86 Leonardtown, Md.   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                   |  |
| PART I. DEATH WAS CAUSED BY:  |  |  |  |
| IMMEDIATE CAUSE (a) <u>CARDIAC ARREST</u>   |  |  |  |
| 4413  |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF  |  |  |  |
| (b) <u>PSEUDOMONAS SEPTIS</u>   |  | 5d   |  |
| DUE TO, OR AS A CONSEQUENCE OF  |  |  |  |
| (c) <u>ORIGINAL RUPTURE ABDOMINAL AORTIC ANEURISM</u>   |  | 24d.   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:  |  |  |  |
| <u>RENAL FAILURE</u>  |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                               |  |
| 1-29-82   |  | RUPTURED ABD. AORTIC ANEURISM  |  |
| 20a. AUTOPSY?   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?                 |  |
| YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | YES <input type="checkbox"/> NO <input type="checkbox"/>                       |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |
|   |  |  |  |
| 21d. INJURY OCCURRED  |  | 21e. PLACE OF INJURY   |  |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | [AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.]                                 |  |
|   |  |  |  |
| 21f. LOCATION   |  | CITY OR TOWN   |  |
|   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) lost  |  | 22c. DATE SIGNED   |  |
| saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  | 2/25/82  |  |
| 22b. SIGNATURE  |  | DEGREE   |  |
| R. Scott Stuart   |  | MD   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  | 22e. ADDRESS   |  |
| R. SCOTT STUART   |  | 601 N. BROADWAY BALT. Md.  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |  | 23b. DATE  |  |
| Burial  |  | 3/1/82   |  |
| 23c. NAME OF CEMETERY OR CREMATORY  |  | 23d. LOCATION  |  |
| Charles Memorial Gen. Leonardtown, St. Mary's   |  | CITY OR TOWN   |  |
| 24. FUNERAL DIRECTOR  |  | 25a. DATE REC'D. BY REGISTRAR  |  |
| W. Clarke Mattingley Leonardtown, Md.   |  | MAR 1 1982   |  |
| 25b. REGISTRAR'S SIGNATURE  |  | Md.  |  |
| Francis J. Nether   |  |  |  |



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RECEIVED  
FEB 1964



RECEIVED  
FEB 1964

RECEIVED  
FEB 1964

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |   |   |   |  |   |  |
|--|--|--|--|---|---|---|--|---|--|
| 1. FOR STATE REGISTRAR   |  |  |  |   | REG. NO.  |   |  |   |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>WILEY WILSON - BEY</b>   |  |  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>2-11-1982</b><br>2b. HOUR<br><b>10.05AM</b> |   |  |   |  |
| 3 SEX<br><b>M</b>  |  | 4. RACE<br><b>B</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>5 2 02</b>   |   | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>79</b> YRS.  |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN. |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>VA</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.                               |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Sinai Hospital</b> |  |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)                                |  | 12b. KIND OF BUSINESS OR INDUSTRY                               |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>MD</b>   |  | 13b. COUNTY<br><b>BALTO.</b>   |  | 13c. CITY OR TOWN<br><b>Baltimore</b>   |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>5407 Gradin Avenue</b>                |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Levi Wilson</b>   |  |  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Lillian Peterson</b>              |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>228-09-1635</b>   |  | 17. INFORMANT<br>ADDRESS<br><b>Katherine Johnson 5407 Gradin Avenue</b>   |   |   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a)<br><b>4960</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>SEVERE CHRONIC OBSTRUCTIVE LUNG DISEASE - 10 Yr</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>CONGESTIVE HEART FAILURE - 1 Yr</b><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>45 minutes.</b> |  |  |  |   |   |   |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:<br><b>Hypertension and COPD.</b>  |  |  |  |   |   |   |  |   |  |
| 19a. DATE OF OPERATION<br><b>NA</b>  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>NA</b>  |  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |   |   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |   |  |   |  |
| 22a. I certify that (I) (the hospital) attended the deceased from <b>2-11-1982</b> to <b>2-11-1982</b> , that (I) (we) lost saw the deceased alive on <b>2/22/82</b> 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.  |  |  |  |   |   |   |  |   |  |
| 22b. SIGNATURE<br><b>William E. Randall Jr</b> M.D.  |  |  |  |   | DEGREE<br><b>M.D.</b>   |   |  | 22c. DATE SIGNED<br><b>2-11-82</b>                              |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>W.E. RANDALL, JR</b>   |  |  |  |   | 22e. ADDRESS<br><b>201 E. UNIV. PKWY BALTO 21218</b>                                  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>2/15/82</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>King Memorial Pk.</b>  |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Co. MD</b>                           |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Wm. C. March F/H</b>  |  |  |  |   | ADDRESS<br><b>1101 E. North Ave.</b>  |   | 25a. DATE REC'D. BY REGISTRAR<br><b>FEB 16 1982</b>  |   |  |
|  |  |  |  |   | 25b. REGISTRAR'S SIGNATURE<br><b>Henry J. [Signature]</b>                             |   |  |   |  |

MISSA - WILSON - 1951

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25

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MISSA - WILSON - 1951

MISSA - WILSON - 1951



MISSA - WILSON - 1951

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| FOR STATE REGISTRAR   |  |   |  | STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  | REG. NO. 8 2 0 4 3 5 7   |  |  |  |
|---|--|---|--|--|--|--|--|--|--|--|--|
| 1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br><b>DAVID (NONE) WIMS</b>   |  |   |  | 2a DATE OF DEATH MONTH DAY YEAR<br><b>2/19/82</b>  |  |  |  | 2b HOUR<br><b>5:18 PM</b>  |  |  |  |
| 3 SEX<br><b>MALE</b>  |  | 4 RACE<br><b>BLACK</b>  |  | 5 DATE OF BIRTH MONTH DAY YEAR<br><b>11 10 1900</b>  |  | 6 AGE (IN YEARS LAST BIRTHDAY) YRS<br><b>81</b>                                |  | IF UNDER 1 YEAR MONTHS DAYS<br><b>3</b>  |  | IF UNDER 24 HRS. HOURS MIN.<br><b></b>   |  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>South Carolina</b>   |  | 7b CITIZEN OF WHAT COUNTRY?<br><b>U.S.</b>  |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.               |  |  |  |  |  |
| 10 CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>BON SECOURS Hospital</b> |  |  |  | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>RETIRED</b> |  | 12b KIND OF BUSINESS OR INDUSTRY<br><b>N/A</b>   |  |  |  |
| 13a STATE<br><b>Maryland</b>  |  |   |  | 13b COUNTY<br><b>Baltimore City</b>  |  | 13c CITY OR TOWN<br><b>Baltimore</b>   |  | 13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 13e STREET ADDRESS<br><b>931 N. Bentalou St.</b>   |  |
| 14 FATHER'S NAME FIRST MIDDLE LAST<br><b>Ben WIMS</b>   |  |   |  | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Alice MOORE</b>  |  |  |  |  |  |  |  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)  |  |   |  | 16b SOCIAL SECURITY NO.<br><b>216-03-0838</b>  |  | 17 INFORMANT ADDRESS<br><b>SARAH WIMS</b>                                      |  |  |  |  |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Renal Failure, Severe Anemia, Congestive Heart Failure.</b><br>5860 } DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last }<br>(b) }<br>(c) } DUE TO, OR AS A CONSEQUENCE OF |  |   |  |  |  |  |  |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a<br><b>Pneumonia &amp; Gout with Polyarticular Involvement.</b>   |  |   |  |  |  |  |  |  |  |  |  |
| 19a DATE OF OPERATION   |  |   |  | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  |  | 20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |  |  |  |  |  |  |  |
| 21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  | 21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |  |  |  |  |  |  |
| 22a I certify that (I) (this hospital) attended the deceased from <b>1/81</b> to <b>2/19/82</b> , that (I) (we) last saw the deceased alive on <b>2/19/82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.  |  |   |  |  |  |  |  |  |  |  |  |
| 22b. SIGNATURE<br><b>Eugene Lundy</b>   |  |   |  | DEGREE<br><b>MD</b>  |  |  |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br><b>2/19/82</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Eugene Lundy</b>  |  |   |  | 22e ADDRESS<br><b>MD 2000 W. Baltimore St. Baltimore, Md 21223</b>   |  |  |  |  |  |  |  |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |  | 23b DATE<br><b>2-24-82</b>  |  | 23c NAME OF CEMETERY OR CREMATORY<br><b>Mt. Auburn Cem.</b>  |  | 23d LOCATION CITY OR TOWN COUNTY STATE<br><b>BALTIMORE MD</b>                  |  |  |  |  |  |
| 24 FUNERAL DIRECTOR NAME<br><b>Joseph L. Russ</b>   |  |   |  | ADDRESS<br><b>2223 W. North Ave.</b>   |  |  |  | 25a DATE REC'D. BY REGISTRAR<br><b>MAR 5 1982</b>  |  | 25b REGISTRAR'S SIGNATURE<br><b>James Jean Nathan</b>  |  |

RECEIVED  
MAR 11 1965

TO: [illegible]  
FROM: [illegible]

SUBJECT: [illegible]

DATE: [illegible]

RE: [illegible]

1. [illegible]

2. [illegible]

3. [illegible]

4. [illegible]

5. [illegible]

6. [illegible]

7. [illegible]

8. [illegible]

9. [illegible]

10. [illegible]

11. [illegible]

12. [illegible]

13. [illegible]

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 4 3 5 8

FOR  
1. STATE  
REGISTRAR

REG. NO.

|   |   |   |  |   |  |
|---|---|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>MILDRED LIVINGSTON WOLF  |   |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>2/28/82   |   | 2b. HOUR<br>10 PM  |
| 3. SEX<br>F FEMALE  | 4. RACE<br>W HITE   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>8 20 12   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>69 YRS.   |   | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>VIRGINIA   | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALT COUNTY MD.  |   |  |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>SINAI HOSPITAL |   | 12a. USUAL RESIDENCE<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>HOUSEWIFE   | 12b. KIND OF BUSINESS OR INDUSTRY<br>AT HOME  |  |
| 13a. STATE<br>MD.   |   | 13b. COUNTY<br>BALTO.   | 13c. CITY OR TOWN<br>BALTIMORE   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS<br>APT. 2-D #21215<br>6930 Brookmill Rd.   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>PHILIP LIVINGSTON   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Dora MILLER  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>NO  |   | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>216/12/7384  | 17. INFORMANT<br>MR. LARRY WOLF 8 BURR OAK CT.<br>Daugether <del>xxxxxx</del> RANDALLSTOWN, MD 21133   |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <u>Respiratory Arrest</u><br>1629<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>metastatic lung disease</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>Liver Disease</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. |   |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)   |   |   |  |   |  |
| 19a. DATE OF OPERATION  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  | 21c. HOW INJURY OCCURRED<br>(ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>2/28/82</u> , 19 <u>82</u> , to <u>2/28/82</u> , 19 <u>82</u> , that (I) (we) lost saw the deceased alive on <u>2/28/82</u> , 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                               |   |   |  |   |  |
| 22b. SIGNATURE<br>P. Brockman   |   |   | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |   | 22c. DATE SIGNED/<br>2/28/82   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>P. BROCKMAN, M.D.  |   |   | 22e. ADDRESS<br>SINAI HOSP. - BALTO., MD   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>BURIAL   | 23b. DATE<br>MAR. 2, 1982   | 23c. NAME OF CEMETERY OR CREMATORY<br>MOSES MONTEFIORE  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>BALTIMORE MARYLAND                                |  |
| 24. FUNERAL DIRECTOR<br>NAME SOL LEVINSON & BROS., INC.<br>ADDRESS 6010 REISTERSTOWN RD. BALTO., MD 21215   |   |   | 25a. DATE REC'D. BY REGISTRAR<br>MAR 4 1982  |   |  |
|   |   |   | 25b. REGISTRAR'S SIGNATURE<br>James VanNathan  |   |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |   | 8 2 0 4 3 5 9   |  |  |  |  |
|---|--|---|---|---|--|--|--|--|
| 1. FOR STATE REGISTRAR  |  |   |   | REG. NO.  |  |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Charles Hunter WOOD</b>   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>Feb. 27, 1982</b> |   |  | 2b. HOUR<br><b>10:35 A</b>   |  |  |
| 3. SEX<br><b>Male</b>   |  | 4. RACE<br><b>White</b>   |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>12/10/1900</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>81</b><br>YRS MONTHS DAYS HOURS MIN.   |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Virginia</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Hamilton Nursing Center</b> |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Conductor</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Railroad</b> |  |
| 13a. STATE<br><b>Maryland</b>   |  | 13b. COUNTY<br><b>-----</b>   |   | 13c. CITY OR TOWN<br><b>Baltimore</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  |  |
| 13e. STREET ADDRESS<br><b>4106 Mary Ave.</b>  |  | 13f. CITY OR TOWN<br><b>21206</b>   |   |   |  |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Benjamin Samuel Wood</b>   |  |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Marian Giles</b>  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>Yes</b>  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>1919-1921</b>   |   | 17. INFORMANT<br>ADDRESS<br><b>Mildred E. Wood---Same as 13e</b>  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Metastatic Carcinoma of prostate</b><br>1850<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. |  |   |   |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH         |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____  |  |   |   |   |  |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |  |
| 22a. I certify that (I) (the hospital) attended the deceased from <b>1-15</b> , 19 <b>82</b> , to <b>2-27</b> , 19 <b>82</b> , that (I) (we) lost saw the deceased alive on <b>2-25</b> , 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.                     |  |   |   |   |  |  |  |  |
| 22b. SIGNATURE<br><b>M. C. Kowalewski</b> MD  |  |   |   | DEGREE<br><b>MD</b>   |  | 22c. DATE SIGNED<br><b>3-1-82</b>  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>M. C. KOWALEWSKI</b>  |  |   |   | 22e. ADDRESS<br><b>8604 HARBOR RD.</b>  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Cremation</b>  |  | 23b. DATE<br><b>3/1/1982</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Green Mount Crematory</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Maryland</b>  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Walter Brooks Bradley, Inc., Balto Md</b>  |  |   |   | 25a. DATE REC'D. BY REGISTRAR<br><b>MAR 4 1982</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Thomas J. Van Natta</b>   |  |  |



15-12

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2

0 4 3 6 0

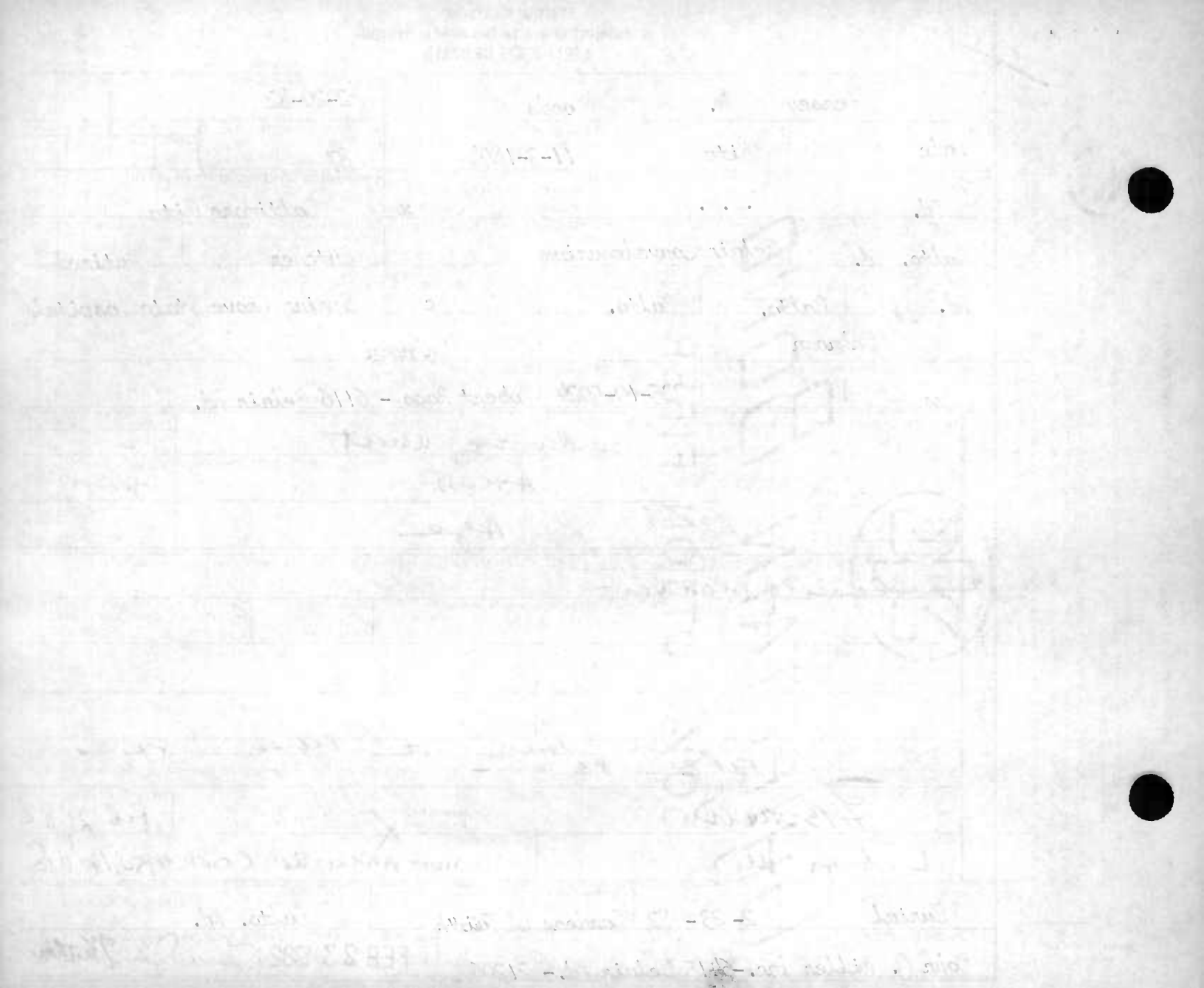
REG. NO.

|  |  |  |  |   |  |  |
|--|--|--|--|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><i>Hersey W. Woods</i>   |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><i>2-20-82</i>                    |   | 2b. HOUR<br>M<br><i>M</i>  |  |
| 3. SEX<br><i>Male</i>  |  | 4. RACE<br><i>White</i>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><i>11-3-1894</i>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><i>87</i> YRS.  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><i>Md.</i>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><i>U.S.A.</i>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><i>Baltimore City</i> MD.  |
| 10. CITY OR TOWN OF DEATH<br><i>Balto. Md.</i>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><i>Belair Convalesarium</i> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><i>Butcher</i>  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><i>Retired</i>  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><i>Md.</i>   |  |  | 13b. COUNTY<br><i>Balto.</i>   |   | 13c. CITY OR TOWN<br><i>Balto.</i>                               |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><i>Unknown</i>   |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><i>Unknown</i>          |   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                            |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><i>Yes</i>   |  |  | 16b. SOCIAL SECURITY NO.<br>(IF GIVE WAR OR DATES)<br><i>225-10-5024</i> |   | 17. INFORMANT<br>ADDRESS<br><i>Robert Ross - 6116 Belair Rd.</i> |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Cardio vas aneur</i><br><i>4292</i><br>DUE TO, OR AS A CONSEQUENCE OF (b) <i>ASCUD</i><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF (c) <i>Age</i> |  |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><i>Years</i>   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><i>Cancer of bladder -</i>   |  |  |  |   |  |  |
| 19a. DATE OF OPERATION<br><i>Feb 20</i>  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><i>Bladder</i>   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><i>P.M. 19</i>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 21b. PART 1 OR PART 2)   |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>Jan 14</i> 19 <i>74</i> to <i>Feb 20</i> 19 <i>82</i> that (we) last saw the deceased alive on <i>Feb 20</i> 19 <i>82</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.                         |  |  |  |   |  |  |
| 22b. SIGNATURE<br><i>L. Boas</i>   |  | DEGREE<br><i>MD</i>  |  |   | 22c. DATE SIGNED<br><i>Feb 21 82</i>                             |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><i>L. BOAS MD</i>   |  | 22e. ADDRESS<br><i>50 SCOTT ADAM Rd Cockeysville MD</i>  |  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><i>Burial</i>  |  | 23b. DATE<br><i>2-23-82</i>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><i>Gardens Of Faith</i>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><i>Balto. Md.</i>  |
| 24. FUNERAL DIRECTOR<br>NAME<br><i>John C. Miller Inc.</i>   |  | ADDRESS<br><i>-6415 Belair Rd. - 21206</i>   |  | 25a. DATE REC'D. BY REGISTRAR<br><i>FEB 23 1982</i>   |  | 25b. REGISTRAR'S SIGNATURE<br><i>James Van Natten</i>  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The certificate may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 3 should be detached for use as the burial-transit permit. This permit must be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  | REG. NO. 8 2 0 4 3 6 1  |  |   |  |
|--|--|---|--|---|--|---|--|
| 1. FOR STATE REGISTRAR   |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR  |  |   |  |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br><b>Harry Francis Wright</b>  |  |   |  | Feb. 9, 1982  |  |   |  |
| 3. SEX<br><b>Male</b>  |  | 4. RACE<br><b>White</b>   |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>Jan. 26, 1901</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY) YRS.<br><b>81</b>   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>4026 Lewiston Ave.</b> |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Driver</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Balto Transit Co</b>  |  |
| 13a. STATE<br><b>Md.</b>   |  | 13b. COUNTY<br><b>Baltimore</b>   |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 13e. STREET ADDRESS<br><b>4026 Lewiston Ave.</b>  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>William Wright</b>   |  |   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Stella May Farver</b>  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><b>No</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>215-03-1993</b>  |  | 17. INFORMANT<br><b>Dena D. Wright</b>  |  | 17. ADDRESS<br><b>4026 Lewiston Ave. Baltimore, Md.</b>   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Carcinoma of prostate with metastasis</b><br><b>1850</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. |  |   |  |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>CHF, ASCVD</b>   |  |   |  |   |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |
| 21d. INJURY OCCURRED<br>WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |   |  |
| 22a. I certify that (1) (this hospital) attended the deceased from <b>2/12</b> , 19 <b>80</b> , to <b>2/9</b> , 19 <b>82</b> , that (1) (we) lost saw the deceased alive on <b>2/11</b> , 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) (did not) view the body after death.                            |  |   |  |   |  |   |  |
| 22b. SIGNATURE <b>Stuart Ross</b> DEGREE <b>MD</b> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>  |  |   |  |   |  | 22c. DATE SIGNED<br><b>2/10/82</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Stuart Ross</b>  |  |   |  | 22e. ADDRESS<br><b>10219 S. Duffield Rd. Owings Mills 21117</b>   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>Feb. 12, 1982</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Taylorville Cemetery</b>   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>Taylorville Md.</b>   |  |
| 24. FUNERAL DIRECTOR<br><b>H. J. Ehlhardt</b>  |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>FEB 11 1982</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Francis J. [Signature]</b>   |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 4 3 6 2

REG. NO.

|   |  |  |   |  |  |  |  |  |   |  |  |
|---|--|--|---|--|--|--|--|--|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>EL SIE</b>  |  |  | FIRST MIDDLE LAST<br><b>WUBBENHORST</b>   |  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>2 20 82</b>   |  |  | 2b. HOUR<br><b>8:04 P.M.</b>  |  |  |
| 3 SEX<br><b>Female</b>  |  |  | 4 RACE<br><b>White</b>  |  |  | 5 DATE OF BIRTH MONTH DAY YEAR<br><b>12 8 1895</b>   |  |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>86</b>   |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>BALTO. Md.</b>  |  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTO CITY</b> MD.  |  |  |
| 10 CITY OR TOWN OF DEATH<br><b>BALTO.</b>   |  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Ardleigh Nursing Home</b> |  |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>HOUSEWIFE</b>   |  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>-</b>   |  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>Md</b>   |  |  | 13b. COUNTY<br><b>-</b>   |  |  | 13c. CITY OR TOWN<br><b>BALTIMORE</b>  |  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                       |  |  |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>CARL BINDEMAN</b>   |  |  | 15 MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>FLORA FICK</b>   |  |  | 13e. STREET ADDRESS<br><b>2711 HAMPDEN AVE.</b>  |  |  |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>   |  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>216-18-489</b>  |  |  | 17 INFORMANT<br>ADDRESS<br><b>KATHERINE MEYER 2711 HAMPDEN AVE.</b>  |  |  |   |  |  |
| 18 CAUSE OF DEATH Enter only one cause per line (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Carcinoma of Pancreas</b><br>1579<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(b) <b>-</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>-</b><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>8 mths.</b> |  |  |   |  |  |  |  |  |   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>Mild Congestive Heart Failure</b>   |  |  |   |  |  |  |  |  |   |  |  |
| 19a. DATE OF OPERATION<br><b>-</b>  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>-</b>  |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |   |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |   |  |  |
| 22a. I certify that (1) <del>this hospital</del> attended the deceased from <b>6-27-81</b> , 19 <b>81</b> , to <b>2-20</b> , 19 <b>82</b> , that (1) <del>we</del> last saw the deceased alive on <b>2-6</b> , 19 <b>82</b> , and that in (my) <del>our</del> opinion death occurred on the date and hour and from the causes stated above, (1) <del>we</del> (did) <del>not</del> view the body after death.                         |  |  |   |  |  |  |  |  |   |  |  |
| 22b. SIGNATURE<br><b>L. Kemper Owens</b>  |  |  | DEGREE<br><b>M.D.</b>   |  |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                 |  |  | 22c. DATE SIGNED  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>L. Kemper Owens</b>   |  |  | 22e. ADDRESS<br><b>300 Armory Place (3D) BALTO MD 21201</b>   |  |  |  |  |  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>BURIAL</b>  |  |  | 23b. DATE<br><b>2-22-82</b>   |  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>CRESTHAWN MEMORIAL GARDENS</b>  |  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Howard Md.</b>   |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>J. Walter Onklew</b>   |  |  | ADDRESS<br><b>5444 BELAIR RD.</b>   |  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>FEB 25 1982</b>  |  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Rene J. [Signature]</b>  |  |  |

MEDICAL CERTIFICATION

35 90 35 100 1 2 9 1

1207 BP



*[Faint, mostly illegible handwritten text on lined paper. The text appears to be a list or series of entries, possibly related to a library or archival collection. Some words like "University" and "Library" are faintly visible.]*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

**(M)**

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

Item 2a 6564 2/25/82 g3

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 4 3 6 3

|   |  |  |  |
|---|--|--|--|
| 1. FOR<br>STATE<br>REGISTRAR  |  | REG. NO.   |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>ANNA CATHERINE WURZBACHER  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>2 1/13/82  |  |
| 2. SEX<br>Female  |  | 2b. HOUR<br>5 A M  |  |
| 3. RACE<br>White  |  | 3. AGE (IN YEARS LAST BIRTHDAY)<br>93 YRS.   |  |
| 4. DATE OF BIRTH<br>MONTH DAY YEAR<br>4 16 88   |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.  |  |
| 5. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland  |  | 6. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.   |  |
| 7a. CITIZEN OF WHAT COUNTRY?<br>USA   |  | 7b. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |
| 8. CITY OR TOWN OF DEATH<br>Baltimore   |  | 9. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>22 S. Athol Avenue                               |  |
| 10. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Food Service   |  | 11. KIND OF BUSINESS OR INDUSTRY<br>Retired  |  |
| 12a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>12a. STATE<br>Md  |  | 12b. COUNTY<br>Baltimore   |  |
| 13a. CITY OR TOWN<br>Baltimore  |  | 13b. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |
| 13c. STREET ADDRESS<br>1730 E. 32nd Street  |  | 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>John A. Richwien   |  |
| 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Elizabeth W. Heinz   |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No   |  |
| 16b. SOCIAL SECURITY NO.<br>220-44-7422   |  | 17. INFORMANT<br>General German Aged Peoples Home<br>22 S. Athol Ave Baltimore, Md. 21229  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Generalized arteriosclerosis</u><br>4140<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>arteriosclerotic heart disease</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>chronic failure</u>  |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a):   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |
| 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  |
| 21c. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21d. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  |
| 21e. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  | 21f. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Mar</u> 19 <u>81</u> to <u>13 Jan</u> 19 <u>82</u> , that (I) (we) last<br>saw the deceased alive on <u>13 Jan</u> 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |  |  |  |
| 22b. SIGNATURE<br><u>William J. Bryson</u>  |  | 22c. DATE SIGNED<br><u>15 Feb 82</u>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>William J. Bryson, M.D.  |  | 22e. ADDRESS<br>5772 Westview Mall Baltimore, Md.  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial  |  | 23b. DATE<br>2/16/82   |  |
| 23c. NAME OF CEMETERY OR CREMATORY<br>Baltimore Cemetery  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore Maryland   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Witzke, P.A.  |  | 25. DATE REC'D. BY REGISTRAR<br>FEB 16 1982  |  |
| 1630 Edmondson Avenue Baltimore, Md.  |  | 25b. REGISTRAR'S SIGNATURE<br><u>James J. Kistner</u>  |  |

64

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG NO

1- FOR  
STATE  
REGISTRAR

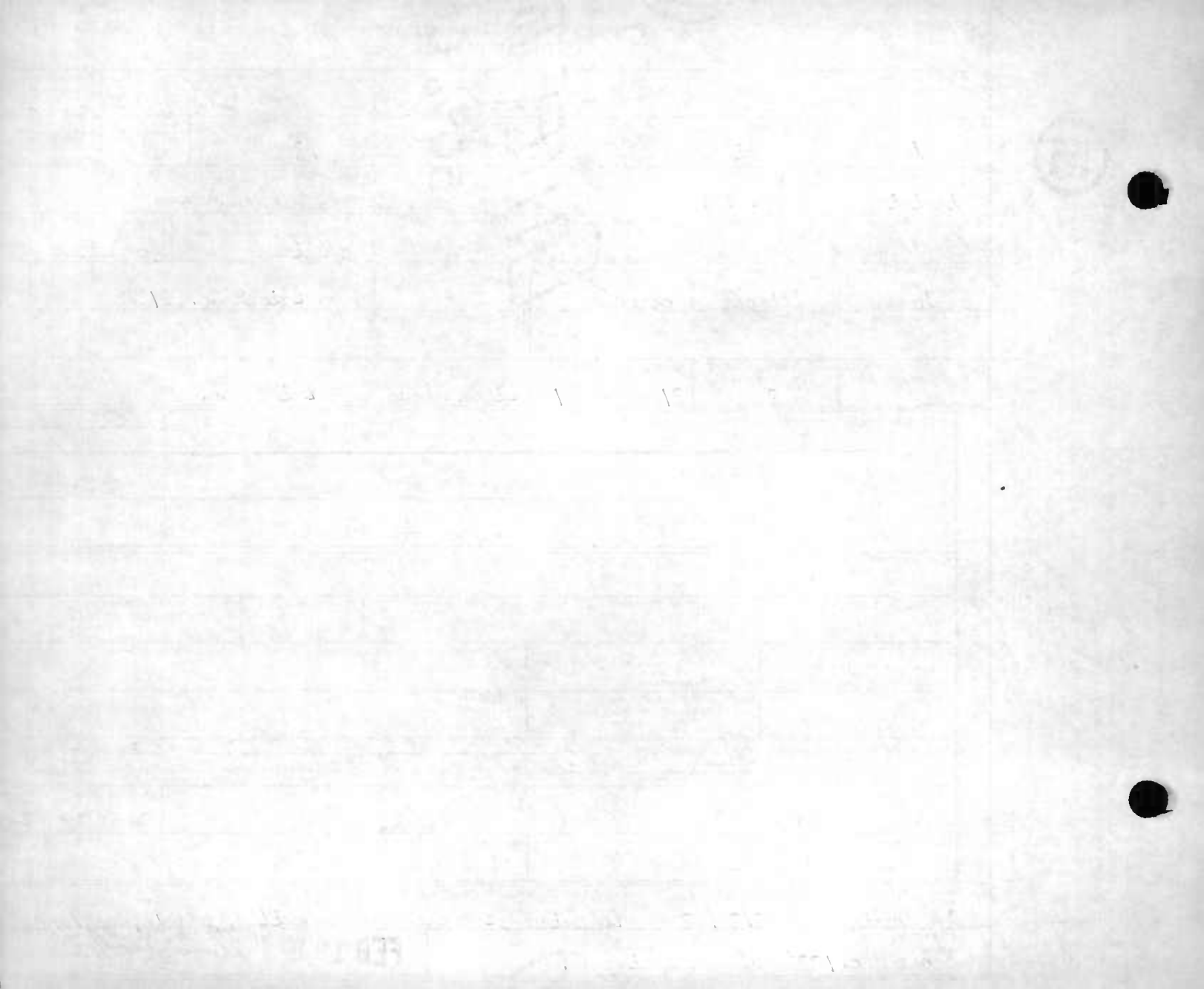
|  |  |  |  |  |   |  |   |  |  |
|--|--|--|--|--|---|--|---|--|--|
| 1 DECEASED NAME<br>(TYPE OR PRINT)<br>James Wyatt  |  |  | 2a DATE OF DEATH<br>MONTH DAY YEAR<br>2 17 82                          |  |   | 2b HOUR<br>8:30 AM   |   |  |  |
| 3 SEX<br>Male  |  | 4 RACE<br>White  |  | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br>4/27/08   |   | 6 AGE (IN YEARS LAST BIRTHDAY)<br>73 YRS   |   |  |  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Virginia   |  | 7b CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |   | 9 BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD   |   |  |  |
| 10 CITY OR TOWN OF DEATH<br>Baltimore  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Baltimore City Hospital |  | 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Repariman   |   | 12b KIND OF BUSINESS OR INDUSTRY<br>Computers  |   |  |  |
| 13a STATE<br>Maryland  |  | 13b COUNTY<br>Baltimore  |  | 13c CITY OR TOWN<br>Rosedale   |   | 13d INSIDE CITY LIMITS<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |   | 13e STREET ADDRESS<br>5665 Leiden Rd. 21206  |  |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST  |  |  |  | 15 MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST   |   |  |   |  |  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>Yes   |  | 16b SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>480 2  |  | 17 INFORMANT<br>Linda Theos 5665 Leiden Rd.  |   |  |   |  |  |
| 18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)<br>PART 1. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) 4960<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } (b) COPD<br>DUE TO, OR AS A CONSEQUENCE OF (c) EVA |  |  |  |  |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |  |  |  |   |  |   |  |  |
| 19a DATE OF OPERATION  |  |  | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED                        |  |   | 20a AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |   |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 2-8 1982, to 2-17 1982, that (I) (we) lost<br>saw the deceased alive on 2-16 1982, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.        |  |  |  |  |   |  |   |  |  |
| 22b. SIGNATURE<br>R. Chen-Tan, MD  |  |  |  |  |   | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   | 22c. DATE SIGNED<br>2-17-82  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>R. CHEN-TAN   |  |  |  |  |   | 22e. ADDRESS<br>Baltimore City Hospital  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial   |  |  | 23b. DATE<br>2/20/82   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Lakeview Cemetery |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Sykesville, Carroll, Maryland |  |  |
| 24 FUNERAL DIRECTOR<br>NAME<br>Ambrose Inc. 1328 Sulphur Spring Rd.  |  |  |  |  |   | 25a. DATE REC'D. BY REGISTRAR<br>FEB 19 1982   |   |  |  |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner (must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  | REG. NO.   |  |  |  |
|--|--|--|--|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>JOHN WYATT</b>  |  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>FEBRAURY 21, 1982</b>  |  |  |  |
| 3. SEX<br><b>Male</b>  |  | 4. RACE<br><b>Black</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>12 1 14</b>   |  | 2b. HOUR<br><b>3:19 pm</b>   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>VA</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 8. AGE (IN YEARS LAST BIRTHDAY)<br><b>67</b>   |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 72 HRS.<br>HOURS MIN.   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Church Home &amp; Hospital</b> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b>  |  | MD   |  |
| 13a. STATE<br><b>MD</b>  |  | 13b. COUNTY<br><b>Baltimore</b>  |  | 13c. CITY OR TOWN<br><b>Baltimore</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Cornelius Wyatt</b>   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Mary Murdock</b>   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)   |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>Yes</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>705-05-3908</b>   |  | 17. INFORMANT<br><b>Edward West</b>  |  | ADDRESS<br><b>1708 Gemini Dr. Eldersburg, MD</b>   |  |
| 18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>VENTRICULAR FIBRILLATION</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>MYOCARDIAL INFARCTION</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>4100<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |  |  |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)<br><b>ANGINA PECTORIS, HYPERTENSION</b>   |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |  |
| 22a. I certify that (I) this hospital attended the deceased from <u>2/20/82</u> 19 <u>82</u> , to <u>2/21/82</u> 19 <u>82</u> , that (I/we) last saw the deceased alive on <u>2/21/82</u> 19 <u>82</u> and that in (my/our) opinion death occurred on the date and hour and from the causes stated above. (If we did not view the body after death, so state.)                                 |  |  |  |  |  |  |  |
| 22b. SIGNATURE<br><i>[Signature]</i>   |  | DEGREE<br><b>MD</b>  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br><b>2/21/82</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>V. SIVAN M.D.</b>  |  | 22e. ADDRESS<br><b>Church Hospital, MD 21231</b>   |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>2/27/82</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Md. Nat'l Mem. Pk.</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Laurel MD</b>   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Wm. C. March F/H</b>  |  |  |  | ADDRESS<br><b>1101 E. North Ave.</b>   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>FEB 23 1982</b>  |  |
|  |  |  |  | 25b. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>   |  |  |  |

TEH 28 KHS (Sung Jang Hyeon)

NOTICE OF CUSTOMER

DATE 1/28/2024





## CERTIFICATE OF DEATH

REG. NO.

FOR  
STATE  
REGISTRAR

|   |  |  |  |  |  |   |  |  |
|---|--|--|--|--|--|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Wyatt</b>  |  |  | 2a. DATE OF DEATH<br>MONTH <b>02</b> DAY <b>15</b> YEAR <b>82</b>                            |  |  | 2b. HOUR<br><b>12:06 PM</b>   |  |  |
| 3. SEX<br><b>Male</b>   |  |  | 4. RACE<br><b>Black</b>  |  |  | 5. DATE OF BIRTH<br>MONTH <b>5</b> DAY <b>5</b> YEAR <b>14</b>  |  |  |
| 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>67</b>  |  |  | 7. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Hanover Co. Va.</b>   |  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.                            |  |  | 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   |  |  |
| 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Provident Hospital</b>  |  |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Bethlehem Stl.</b>    |  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>STEEL</b>   |  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE <b>Md.</b>   |  |  | 13b. CITY OR TOWN<br><b>BALTO</b>  |  |  | 13c. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |  |
| 14. FATHER'S NAME<br>FIRST <b>Alex</b> MIDDLE <b>Wyatt</b> LAST <b>Mallory</b>  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>Elizabeth</b> MIDDLE <b>Mallory</b> LAST <b>Mallory</b> |  |  | 16. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>No</b>   |  |  |
| 16b. SOCIAL SECURITY NO.<br><b>218-07-4736</b>  |  |  | 17. INFORMANT<br><b>Mrs. Marion O. Wyatt</b>   |  |  | 17. ADDRESS<br><b>3904 MAINE AVE.</b>   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c):<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiac arrest</b><br><b>4140</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Atherosclerotic Heart Dz c/ Ischemia</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last |  |  |  |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a):   |  |  |  |  |  |   |  |  |
| 19a. DATE OF OPERATION  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                   |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                       |  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>Feb 15</b> 19 <b>82</b> to <b>Feb 15</b> 19 <b>82</b> , that (I) (we) last saw the deceased alive on <b>Feb 15</b> 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                    |  |  |  |  |  |   |  |  |
| 22b. SIGNATURE<br><b>D. Bell, M.D.</b>  |  |  | DEGREE   |  |  | 22c. DATE SIGNED<br><b>2-15-82</b>  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>D. Bell, M.D.</b>   |  |  | 22e. ADDRESS<br><b>Provident Hospital - 2600 Liberty Heights</b>                             |  |  | 22f. DATE REC'D. BY REGISTRAR<br><b>Francis J. Smith</b>  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>BURIAL</b>  |  |  | 23b. DATE<br><b>2-19-82</b>  |  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Arbutus</b>  |  |  |
| 23d. LOCATION<br>CITY OR TOWN<br><b>BALTO</b>   |  |  | 23e. COUNTY<br><b>MD</b>   |  |  | 23f. STATE<br><b>MD</b>   |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>JAS. A. MORTON &amp; SONS</b>  |  |  | 24. ADDRESS<br><b>1701 Laurens</b>   |  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>FEB 17 1982</b>   |  |  |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 7 days after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |                         |   |  | REG. NO.  |  |   |  |
|---|-------------------------|---|--|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>GARY LEROY WYNN</b>  |                         |   |  | 2a. DATE OF DEATH<br>MONTH <b>2</b> DAY <b>13</b> YEAR <b>82</b>  |  | 2b. HOUR<br><b>11:30 P</b>  |  |
| 3. SEX<br><b>M</b>  | 4. RACE<br><b>NEGRO</b> | 5. DATE OF BIRTH<br>MONTH <b>12</b> DAY <b>15</b> YEAR <b>43</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>38</b> YRS.   |  | IF UNDER 1 YEAR<br>MONTHS <b></b> DAYS <b></b>  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN)<br><b>Maryland</b>  |                         | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City.</b> MD.  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   |                         | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN EACH FACTORY, STREET AND NO.)<br><b>SOUTH BALTIMORE GEN. HOSP.</b>  |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Gardener</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b></b>  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>STATE <b>MD</b> COUNTY <b>Baltimore</b> CITY OR TOWN <b>Baltimore</b>   |                         | 13b. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 13c. STREET ADDRESS<br><b>2500 Giles Road</b>   |  | 13d. CITY OR TOWN<br><b>Baltimore</b>   |  |
| 14. FATHER'S NAME<br>FIRST <b>John</b> MIDDLE <b></b> LAST <b>WYNN</b>  |                         | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>Elizabeth</b> MIDDLE <b>Wynn</b> LAST <b></b>  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN) <b>?</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>215-40-5694</b>  |  |
| 17. INFORMANT<br>ADDRESS<br><b>Marcella Wynn 2500 Giles Apt. A</b>  |                         | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), (c).<br>PART 1. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <b>Cardio - Pulmonary collapse</b><br><b>D389</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Sepsis, ARDS, pneumonia</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b></b> |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br><b></b>  |  | PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a                                  |  |
| 19a. DATE OF OPERATION  |                         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                       |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |                         | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M.</b> <b>19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |                         | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from<br>saw the deceased alive on <b>2/13</b> 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above. (If not, find and did not view the body after death. |                         | 22b. SIGNATURE<br><b>Steven W. Eaton MD</b>   |  | 22c. DATE SIGNED<br><b>2/13/82</b>  |  | 22d. DEGREE<br><b>MD</b> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  |
| 22e. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Steven W. Eaton</b>   |                         | 22f. ADDRESS<br><b>3001 S. HANOVER ST. Baltimore, MD.</b>   |  | 23a. NAME OF CEMETERY OR CREMATORY<br><b>Cedar Hill Cem.</b>  |  | 23b. LOCATION<br><b>Barto. A.A. Md.</b>   |  |
| 23c. RITUAL, CREMATION, REMOVAL<br><b>Burial</b>  |                         | 23d. DATE<br><b>2/18/82</b>   |  | 23e. NAME OF CEMETERY OR CREMATORY<br><b>Cedar Hill Cem.</b>  |  | 23f. LOCATION<br><b>Barto. A.A. Md.</b>   |  |
| 24. FUNERAL DIRECTOR<br><b>Chas. A. Rice FSPA. 1300 Eutaw Pl</b>  |                         |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>FEB 17 1982</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>James J. [Signature]</b>   |  |



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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

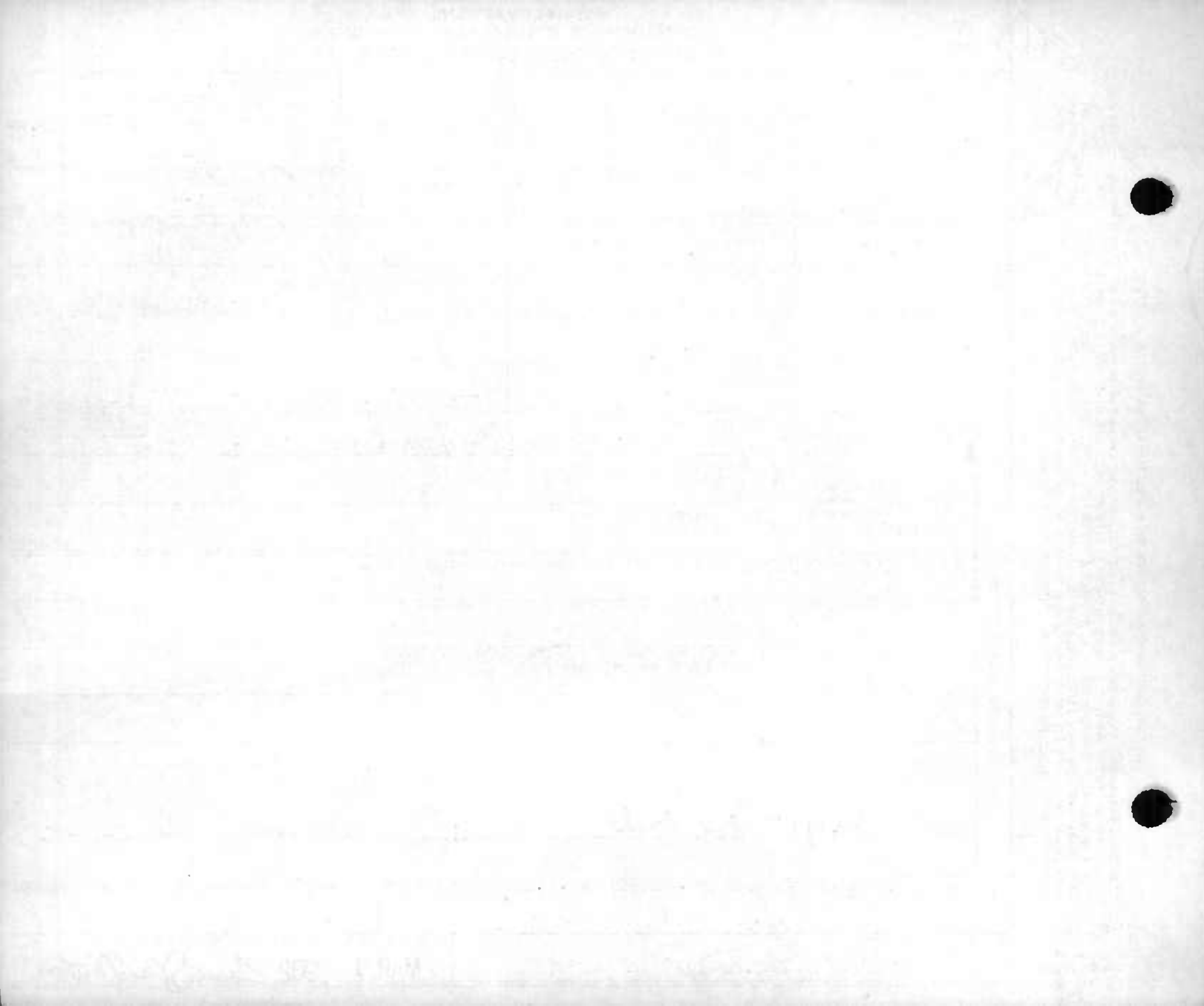
DHMH-17  
(VR A15 ME (5))  
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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

|  |  |  |  |   |  |   |  |  |  |                                |  |       |  |     |  |      |  |          |  |
|--|--|--|--|---|--|---|--|--|--|--------------------------------|--|-------|--|-----|--|------|--|----------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  | FIRST  |  | MIDDLE  |  | LAST  |  | 2a. DATE KNOWN<br>OF DEATH                 |  | ESTI-<br>MATED                 |  | MONTH |  | DAY |  | YEAR |  | 2b. HOUR |  |
| ROBERT   |  | H.   |  | YARBOROUGH  |  |   |  | 2-26-82                                    |  | 19                             |  |       |  |     |  |      |  |          |  |
| 3. SEX   |  | 4. RACE  |  | 5. DATE OF BIRTH  |  | 6. AGE (IN YEARS<br>LAST BIRTHDAY)                                  |  | IF UNDER 24 HRS.                           |  | 7c. DATE<br>PRONOUNCED<br>DEAD |  | MONTH |  | DAY |  | YEAR |  | 2d. HOUR |  |
| male   |  | black  |  | 4 30 09   |  | 72 YRS.   |  |  |  | 2-26-82                        |  | 19    |  |     |  |      |  |          |  |
| 7a. BIRTHPLACE (STATE OR<br>FOREIGN COUNTRY)   |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>   |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |  |  |  |                                |  |       |  |     |  |      |  |          |  |
| N.Y.   |  | USA  |  |   |  | Baltimore City  |  |  |  |                                |  |       |  |     |  |      |  |          |  |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)                         |  | 12a. USUAL OCCUPATION (TYPE OF WORK<br>FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS<br>OR INDUSTRY                                |  |  |  |                                |  |       |  |     |  |      |  |          |  |
| Baltimore  |  | 1321 N. Eden Street  |  |   |  |   |  |  |  |                                |  |       |  |     |  |      |  |          |  |
| 13a. STATE   |  | 13b. COUNTY  |  | 13c. CITY OR TOWN   |  | 13d. INSIDE CITY LIMITS?  |  | 13e. STREET ADDRESS                        |  |                                |  |       |  |     |  |      |  |          |  |
| Md.  |  |  |  | Balto.  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 1321 N. Eden Street                        |  |                                |  |       |  |     |  |      |  |          |  |
| 14. FATHER'S NAME  |  | 15. MOTHER'S MAIDEN NAME   |  |   |  |   |  |  |  |                                |  |       |  |     |  |      |  |          |  |
| Luther   |  | Malinda  |  |   |  |   |  |  |  |                                |  |       |  |     |  |      |  |          |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)  |  | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT   |  | ADDRESS   |  |  |  |                                |  |       |  |     |  |      |  |          |  |
| Yes  |  | 213-09-3359  |  | Pricilla B. Yarborough  |  | 1321 N. Eden St   |  |  |  |                                |  |       |  |     |  |      |  |          |  |
| WWII   |  |  |  |   |  |   |  |  |  |                                |  |       |  |     |  |      |  |          |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardiovascular disease</u><br>4292<br>Conditions, if any, which<br>gave rise to immediate<br>cause (a) stating the <u>under-</u><br><u>lying cause lost.</u> |  | (b) _____<br>DUE TO, OR AS A CONSEQUENCE OF  |  | (c) _____<br>DUE TO, OR AS A CONSEQUENCE OF   |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH                     |  |  |  |                                |  |       |  |     |  |      |  |          |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).  |  |  |  |   |  |   |  |  |  |                                |  |       |  |     |  |      |  |          |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  | 20. AUTOPSY?  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |  |                                |  |       |  |     |  |      |  |          |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR<br>CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |  |  |                                |  |       |  |     |  |      |  |          |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME,<br>STREET, FACTORY, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |  |  |                                |  |       |  |     |  |      |  |          |  |
| 22a. I certify that I took charge of the remains described above, held on  |  | Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion |  | death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  | TITLE (SPECIFY)<br>M.D. Assistant MEDICAL EXAMINER                  |  | DATE<br>SIGNED 2-26-82                     |  |                                |  |       |  |     |  |      |  |          |  |
| ACTUAL<br>SIGNATURE  |  | Margarita A. Koroll, M.D.  |  | ADDRESS 111 Penn Street   |  |   |  |  |  |                                |  |       |  |     |  |      |  |          |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)   |  | 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)   |  | 23b. DATE   |  | 23c. NAME OF CEMETERY OR CREMATORY                                  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE |  |                                |  |       |  |     |  |      |  |          |  |
|  |  | Burial   |  | 3/3/82  |  | Md. Vet Cem.  |  | Crownsville, Md.                           |  |                                |  |       |  |     |  |      |  |          |  |
| 24. FUNERAL DIRECTOR<br>NAME   |  | 25a. DATE REC'D. BY REGISTRAR  |  | 25b. REGISTRAR'S SIGNATURE  |  |   |  |  |  |                                |  |       |  |     |  |      |  |          |  |
| Wm C March F/H, Inc.   |  | 1101 E. North Ave.   |  | MAR 1 1982  |  | James J. Nathan   |  |  |  |                                |  |       |  |     |  |      |  |          |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the medical examiner, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

82 04369

FOR  
STATE  
REGISTRAR

REG. NO.

|  |   |   |   |   |  |
|--|---|---|---|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>JAMES W YARBROUGH</b>   |   |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>2 / 14 / 82</b>                                       |   | 2b. HOUR<br><b>4:20</b> M  |
| 3. SEX<br><b>M</b>   | 4. RACE<br><b>B</b>   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>10 23 33</b>   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>48</b> YRS.   |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br><b>N.C.</b>  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>CITY</b> MD.   |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTO</b>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>NORTH CHARLES GEN. HOSP</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Engineer</b>             |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Housing</b>  |
| 13a. STATE<br><b>MD</b>  | 13b. COUNTY   | 13c. CITY OR TOWN<br><b>BALTO</b>   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS<br><b>507 Colleen Rd.</b>   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Winfred Yarbrough</b>   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Parz Lee Davis</b>  |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)   | 16b. SOCIAL SECURITY NO.  | 17. INFORMANT<br>ADDRESS<br><b>Mrs. Barbara Yarbrough, 507 Colleen Rd</b>   |   |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>PNEUMONIA, BILATERAL</b><br><b>4310</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>INTRACEREBRAL BLEEDING</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>UPPER GI BLEEDING</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. |   |   |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>28 days</b>   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)   |   |   |   |   |  |
| 19a. DATE OF OPERATION   |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                        | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. <b>19</b>   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)                              |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |
| 22. I certify that (I) (the hospital) attended the deceased from <b>1/24, 19 82</b> , to <b>2/14, 19 82</b> , that (I) (we) lost saw the deceased alive on <b>2/14, 19 82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |   |   |   |   |  |
| 22b. SIGNATURE<br><b>A. C. Chouvalit, M.D.</b>   |   | DEGREE  |   | 22c. DATE SIGNED<br><b>2/14/82</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>A. C. CHOUVALIT, M.D.</b>  |   | 22e. ADDRESS<br><b>NEGH, 28th Delaware St. 21217</b>  |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  | 23b. DATE<br><b>2-19-82</b>   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>KING MEM PK</b>  |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>RANDOLPHSTOWN Md.</b>                                      |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>JAS. A. MORTON &amp; SONS</b>   |   | ADDRESS<br><b>1701 Laurens</b>  |   | 25a. DATE REC'D. BY REGISTRAR<br><b>FEB 17 1982</b><br>25b. REGISTRAR'S SIGNATURE<br><b>James VanNathan</b> |  |



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LIBRARY



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of same.

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |   |   |   |  |  |  |
|--|---|---|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |   | FIRST<br>HARRY  | MIDDLE<br>LEE   | LAST<br>YORK   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>FEBRUARY 19 82  | 2b. HOUR<br>8:00am.  |
| 3. SEX<br>MALE   | 4. RACE<br>WHITE  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>OCT 23 1914   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>67 YRS.   | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>TENN  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTO. CITY MD.  |  |  |
| 10. CITY OR TOWN OF DEATH<br>BALTO.  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>CHURCH HOME HOSPITAL |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>PAINTER  |  | 12b. KIND OF BUSINESS OR INDUSTRY                            |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |   |   |   |  |  |  |
| 13a. STATE<br>MD   | 13b. COUNTY   | 13c. CITY OR TOWN<br>BALTO  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS<br>18 S. ANN ST.   |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>CHARLIE YORK   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>BESSIE   |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>NO   |   | 16b. SOCIAL SECURITY NO.<br>232-28-6468   |   | 17. INFORMANT<br>ADDRESS<br>CALLIE YORK 18 S. ANN ST.  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>1889 IMMEDIATE CAUSE (a) <u>TERMINAL CARCINOMATOSIS</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>CARCINOMA BLADDER</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. |   |   |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                 |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)   |   |   |   |  |  |  |
| 19a. DATE OF OPERATION   |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 2-19-82 to 2-19-82, that (I) (we) lost saw the deceased alive on 2-19-82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |   |   |   |  |  |  |
| 22b. SIGNATURE<br>Sompalli Prasad  |   |   |   | 22c. DATE SIGNED   |  | 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>PRASAD SOMPALLI     |
| 22e. ADDRESS<br>100 N. CHURCH HOSPITAL CORPORATION BROADWAY  |   |   |   | 22f. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>BURIAL   |   | 23b. DATE<br>2-22-82  |   | 23c. NAME OF CEMETERY OR CREMATORY<br>CRESTLAWN  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>SYKESVILLE MD. |
| 24. FUNERAL DIRECTOR<br>NAME<br>JOHN M. WEBER & SONS INC.  |   |   |   | 25a. DATE REC'D. BY REGISTRAR<br>FEB 24 1982   |  | 25b. REGISTRAR'S SIGNATURE<br>[Signature]                    |

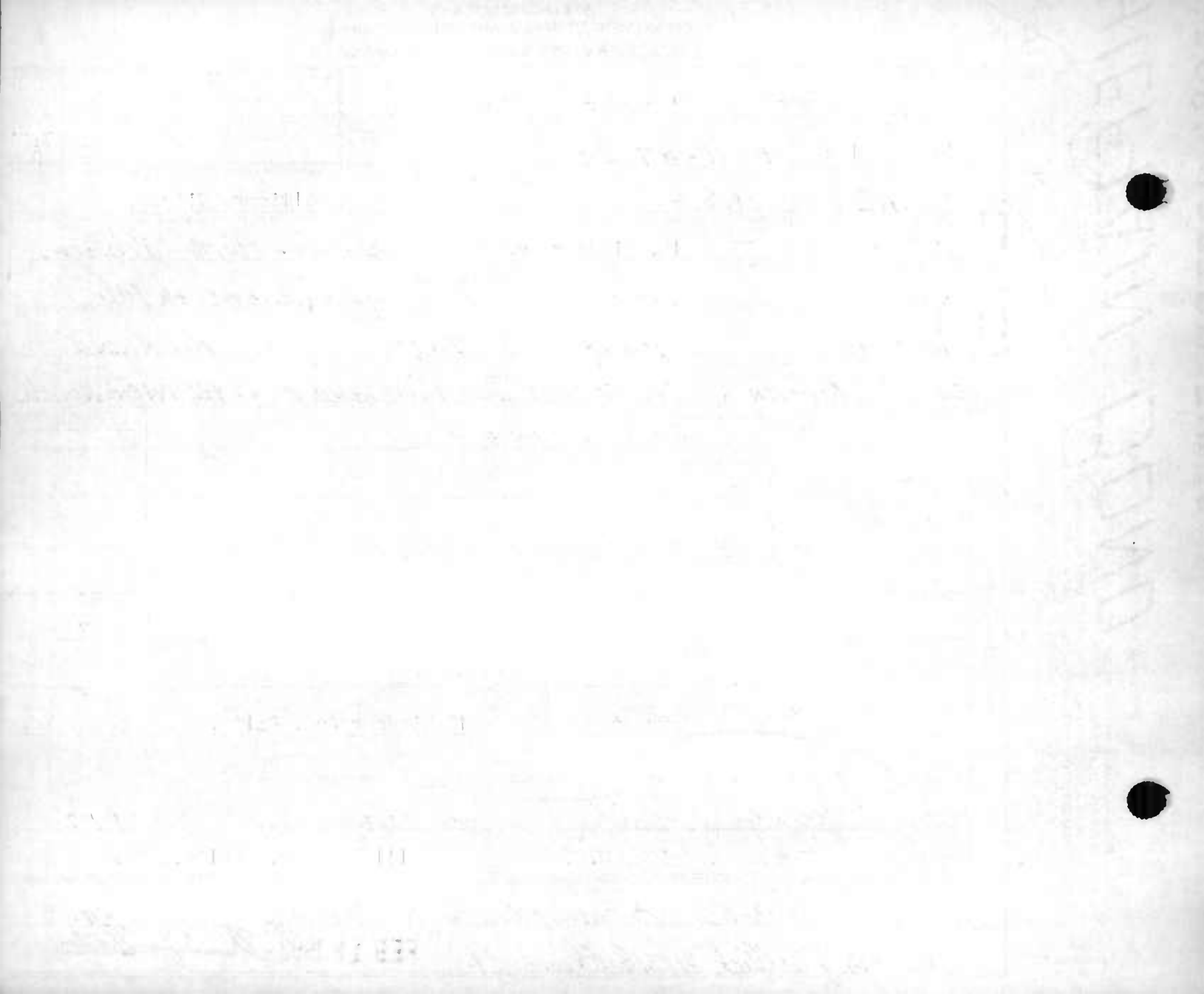
ADDRESS 401 S.

25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE

100-103

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR OR TO FUNERAL DIRECTOR; PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |               |  |  |   |                  |  |  |   |  | REG. NO. 04371 |  |
|--|---------------|--|--|---|------------------|--|--|---|--|----------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) Eugene Alexander Young   |               |  |  |   |                  | 2a. DATE KNOWN OF DEATH<br>ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 2 8 1982 |  | 2b. HOUR M 7:01 P M   |  |                |  |
| 3. SEX Male  | 4. RACE Black | 5. DATE OF BIRTH<br>MONTH DAY YEAR 4-11-47   | 6. AGE (IN YEARS)<br>LAST BIRTHDAY 34 YRS. | IF UNDER 1 YR.<br>MONTHS DAYS HOURS MIN.  | IF UNDER 24 HRS. | 2c. DATE PRONOUNCED DEAD<br>MONTH DAY YEAR 2 8 1982  |  | 2d. HOUR M 7:01 P M   |  |                |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) N.C.   |               | 7b. CITIZEN OF WHAT COUNTRY? U.S.A.  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City, MD.                                      |  |   |  |                |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore   |               | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>2800 Blk. Windsor Avenue |  |   |                  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Slipping Clerk                  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Printers                                       |  |                |  |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |               |  |  |   |                  |  |  |   |  |                |  |
| 13a. STATE Md.   |               | 13b. COUNTY  |  | 13c. CITY OR TOWN Balto.  |                  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>     |  | 13e. STREET ADDRESS<br>4305 WENE WORTH RD.  |  |                |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST Lucious YOUNG   |               |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST Ida Kirkland  |                  |  |  |   |  |                |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN) yes VIETNAM  |               |  |  | 16b. SOCIAL SECURITY NO. 215-50-4212  |                  | 17. INFORMANT ADDRESS<br>Ida Kirkland Young 4305 WENE WORTH                                      |  |   |  |                |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>9654 IMMEDIATE CAUSE (a) Gunshot wound to chest<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.   |               |  |  |   |                  |  |  |   |  |                |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).  |               |  |  |   |                  |  |  |   |  |                |  |
| 19a. DATE OF OPERATION   |               |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |                  |  |  | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |                |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |               |  |  | 21b. TIME OF INJURY<br>HOUR MIN MONTH DAY YEAR 6:45 M 2 8 1982  |                  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)<br>Subject shot    |  |   |  |                |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>   |               |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)<br>street   |                  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br>2800 Blk Windsor Ave. Balto. MD.            |  |   |  |                |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> |               |  |  |   |                  |  |  |   |  |                |  |
| ACTUAL SIGNATURE<br>Thomas D. Smith, M.D.  |               |  |  | TITLE (SPECIFY)<br>M Deputy Chief MEDICAL EXAMINER  |                  |  |  | DATE SIGNED<br>2/9/82   |  |                |  |
| EXAMINER'S NAME (TYPE OR PRINT)<br>Thomas D. Smith, M.D.   |               |  |  | ADDRESS<br>111 Penn St. Balto., MD.   |                  |  |  |   |  |                |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial  |               | 23b. DATE<br>2-13-82   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Arbutus Mem Park  |                  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Arbutus MD.  |  |   |  |                |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Randolph J. Collick  |               |  |  | ADDRESS<br>2413 E. Oliver St.   |                  | 25a. DATE REC'D BY REGISTRAR<br>FEB 18 1982  |  | 25b. REGISTRAR'S SIGNATURE<br>Thomas J. [Signature]                                 |  |                |  |



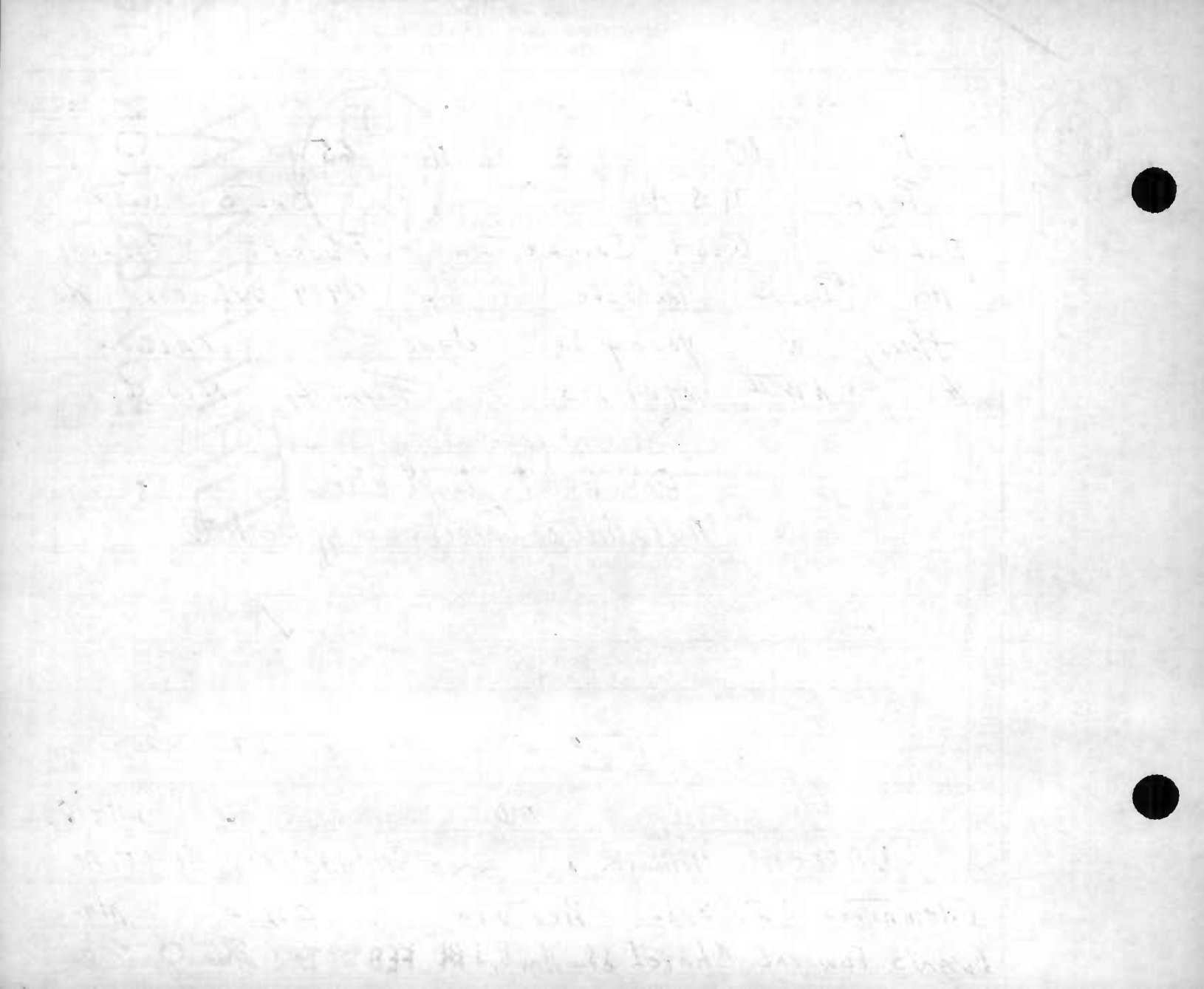
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  |   |  |  |  |  |  | 8 2 0 4 3 7 2  |  |
|--|--|---|--|---|--|--|--|--|--|--|--|
| 1. FOR<br>STATE<br>REGISTRAR   |  | REG. NO.  |  |   |  |  |  |  |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  | FIRST<br>Harry  |  | MIDDLE<br>K   |  | LAST<br>Young Jr.  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>02 17 82  |  | 2b. HOUR<br>3:25P  |  |
| 3. SEX<br>M.   |  | 4. RACE<br>W.   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>8 16 16   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>65 yrs. YRS.                                      |  | IF UNDER 1 YEAR<br>MONTHS DAYS   |  | IF UNDER 24 HRS.<br>HOURS MIN.                           |  |
| 7a. BIRTHPLACE<br>(COUNTRY)<br>Penn  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTO C.TY MD.                               |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>BALTO   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Good Samaritan |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>FLORIST          |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Flowers.  |  |  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>10. STATE Md 11b. COUNTY BALTO 13c. CITY OR TOWN Parkville   |  |   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 13e. STREET ADDRESS<br>1719 Dalesford Rd   |  |  |  |  |  |
| 14. FATHER'S NAME<br>Harry N Young Sr  |  |   |  | 15. MOTHER'S MAIDEN NAME<br>Jane Callow   |  |  |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES NO OR UNKNOWN)<br>Yes   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES GIVE WAR DATES)<br>WW II 189-07-2913  |  | 17. INFORMANT<br>Family Records   |  |  |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>1850 IMMEDIATE CAUSE (a) Cardio-respiratory arrest.<br>DUE TO, OR AS A CONSEQUENCE OF:<br>(b) Cerebral infection.<br>(c) Metastatic Carcinoma of Prostate.<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |   |  |   |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>3-4 yrs. |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I:   |  |   |  |   |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART I OR PART 2)  |  |  |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 2-6-1982 to 2-17-1982 that (I) (we) lost<br>saw the deceased alive on 2-17-1982, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.  |  |   |  |   |  |  |  |  |  |  |  |
| 22b. SIGNATURE<br>VASEEM MALIK MD  |  |   |  | DEGREE<br>MD, ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>    |  |  |  | 22c. DATE SIGNED<br>2/17/82  |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>VASEEM MALIK MD   |  |   |  | 22e. ADDRESS<br>Good Samaritan Hospital   |  |  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(CHECK)<br>Cremation  |  | 23b. DATE<br>2/18/82  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Westview  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>BALTO MD                               |  |  |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Evan's Funeral Chapel 8800 Harford Rd  |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br>FEB 22 1982  |  | 25b. REGISTRAR'S SIGNATURE<br>Thomas J. [Signature]                                  |  |  |  |  |  |





TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 2 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed within 48 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  |   |  |  |  |  |  |  |  |
|---|--|---|--|---|--|--|--|--|--|--|--|
| 1- FOR STATE REGISTRAR  |  |   |  |   |  |  |  |  |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>Virginia E. Young</b>  |  |   |  |   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>February 27, 1982</b>  |  |  |  | 2b. HOUR<br><b>8:45P M</b>   |  |
| 3. SEX<br><b>Female</b>   |  | 4. RACE<br><b>Black</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>7 23 27</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>54</b>   |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br><b>YRS.</b>  |  | IF UNDER 24 HRS<br>HOURS MIN.<br><b>MD.</b>  |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br><b>D.C.</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b>  |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Maryland General Hospital</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)   |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |  |  |
| 13a. STATE<br><b>MD</b>   |  | 13b. COUNTY   |  | 13c. CITY OR TOWN<br><b>Baltimore</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 13e. STREET ADDRESS<br><b>1808 N. Calvert St.</b>  |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Percy S. Tolson</b>  |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE<br><b>Martha Gordon</b>  |  |  |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>578-28-2302</b>   |  | 17. INFORMANT<br>ADDRESS<br><b>Herbert H. Young 1808 N. Calvert St.</b>   |  |  |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiac Arrest</b><br><b>4275</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(b) <b>Respiratory Arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)                 |  |   |  |   |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>40 minutes</b><br><b>40 minutes</b> |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:<br><b>History of Carcinoma of the Lung</b>   |  |   |  |   |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |  |  |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |  |  |  |  |
| 22a. I certify that <del>XX</del> (this hospital) attended the deceased from <b>February 27, 1982</b> , to <b>February 27, 1982</b> , that <del>XX</del> (we) lost saw the deceased alive on <b>February 27, 1982</b> , and that in <del>XX</del> (our) opinion death occurred on the date and hour and from the causes stated above <del>XX</del> (we) (did) (do not) view the body after death. |  |   |  |   |  |  |  |  |  |  |  |
| 22b. SIGNATURE<br><b>K. Kassler-Taub, MD</b>  |  |   |  |   |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br><b>2/27/82</b>   |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Kenneth Kassler-Taub MD</b>   |  |   |  |   |  | 22e. ADDRESS<br><b>c/o Maryland General Hospital</b>   |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>3/4/82</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Md. Veteran Cem.</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Crownsville MD</b>  |  |  |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Wm. C. March F/H 1101 E. North Ave.</b>  |  |   |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>MAR 1 1982</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>James J. Nathan</b>   |  |  |  |

RECEIVED  
FEBRUARY 27 1962  
U.S. DEPARTMENT OF JUSTICE

February 27, 1962

John

Virginia

Salisbury City

Harvard General Hospital

Salisbury

no minutes

Corning Address

no minutes

Washington Address

History of actions of the Board

no

February 27

February 27

February 27

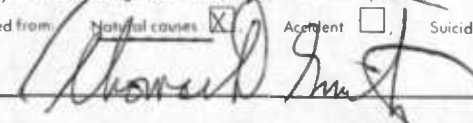
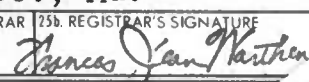
no

no

Harvard General Hospital

General Hospital

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 1 OF YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |  |  |  |   |  |  |  |   |  | REG. NO. 2 0 4 3 7 4   |  |
|--|--|--|--|---|--|--|--|---|--|--|--|
| 1. FOR STATE REGISTRAR   |  |  |  |   |  |  |  |   |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br>William E. Zadera  |  |  |  |   |  |  |  |   |  | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH DAY YEAR<br>2 23 19 82 |  |
| 3. SEX<br>male   |  | 4. RACE<br>white   |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>7-18-1918  |  | 6. AGE (IN YEARS LAST BIRTHDAY) YRS.<br>63   |  | IF UNDER 1 YR. MONTHS DAYS  |  | 2c. DATE PRONOUNCED DEAD MONTH DAY YEAR<br>2 23 19 82                                    |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Balto.  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City                                       |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Naval Acad.  |  | 2d. HOUR<br>2:50 a   |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore   |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Baltimore City Hospital |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Baker                       |  |   |  |  |  |
| 12. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |  |  |   |  |  |  |   |  |  |  |
| 13a. STATE<br>Md.  |  | 13b. COUNTY<br>Balto.  |  | 13c. CITY OR TOWN<br>Balto.   |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS<br>1810 Summit Ave. 21237   |  |  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>August Zadera   |  |  |  |   |  |  |  |   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Hermina Link                               |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)<br>yes  |  | 16b. SOCIAL SECURITY NO.<br>1945-1946  |  | 17. INFORMANT<br>Marie Zadera   |  | ADDRESS<br>1810 Summit Avenue  |  | 21237   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardiovascular disease</u><br>4292<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b) _____<br>(c) _____<br>DUE TO, OR AS A CONSEQUENCE OF  |  |  |  |   |  |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).  |  |  |  |   |  |  |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  |  |  | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                    |  |  |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  |  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)                |  |   |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |   |  |  |  |
| 22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion |  |  |  |   |  |  |  |   |  |  |  |
| ACTUAL SIGNATURE<br>  |  |  |  | TITLE (SPECIFY)<br>M.D. Deputy Chief  |  |  |  | DATE SIGNED<br>2-23-82  |  |  |  |
| EXAMINER'S NAME (TYPE OR PRINT)<br>Thomas D. Smith, M.D.   |  |  |  | ADDRESS<br>111 Penn St.   |  |  |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial  |  | 23b. DATE<br>2-26-82   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Holy Redeemer Cem.  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>Balto., Md.                                       |  |   |  |  |  |
| 24. FUNERAL DIRECTOR NAME<br>Schimunek Funeral Home, Inc.<br>9705 Belair Road 21236  |  |  |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br>MAR 1 1982  |  | 25b. REGISTRAR'S SIGNATURE<br> |  |  |  |

East Street

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |   |  |  |  |   |  |   | 8 2 0 4 3 7 5                     |  |
|---|--|---|---|--|--|--|---|--|---|-----------------------------------|--|
| 1- FOR STATE REGISTRAR  |  |   | REG. NO.  |  |  |  |   |  |   |                                   |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br>Joseph F. Zito  |  |   | 2a. DATE OF DEATH<br>Feb. 10, 1982  |  |  | 2b. HOUR<br>M  |   |  |   |                                   |  |
| 3 SEX<br>Male   |  | 4 RACE<br>White   |   | 5 DATE OF BIRTH<br>March 6, 1895   |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br>86   |   | 7. IF UNDER 1 YEAR<br>MONTHS DAYS  |   | 7b. IF UNDER 24 HRS<br>HOURS MIN. |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Italy  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |   | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.  |   |  |   |                                   |  |
| 10 CITY OR TOWN OF DEATH<br>Baltimore   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>2022 Crestview Rd. |   |  |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Barber   |   | 12b. KIND OF BUSINESS OR INDUSTRY<br>Hair Care   |   |                                   |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>Md.   |  |   | 13b. COUNTY   |  | 13c. CITY OR TOWN<br>Baltimore                           |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br>2022 Crestview Rd. |                                   |  |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br>Francis Zito   |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Rose Fertitta            |  |  |  |   |  |   |                                   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>Yes   |  |   | 16b. SOCIAL SECURITY NO<br>(IF YES, GIVE WAR OR DATES)<br>WWI 218-32-1182 |  | 17 INFORMANT ADDRESS<br>Concetta R. Zito (same as 13e)   |  |   |  |   |                                   |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u><br>4100<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:<br>(b) _____<br>(c) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>acute</u> |  |   |   |  |  |  |   |  |   |                                   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a):<br><u>Mebarbates carcinoma? primary site</u>  |  |   |   |  |  |  |   |  |   |                                   |  |
| 19a. DATE OF OPERATION  |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                          |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |                                   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |   |  |   |                                   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)    |  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |   |  |   |                                   |  |
| 22a. I certify that (1) (this hospital) attended the deceased from <u>Dec 81</u> to <u>Feb 10</u> , 19 <u>82</u> , that (1) (we) last saw the deceased alive on <u>Dec 81</u> , 19 <u>81</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (If we did not view the body after death, so state.)  |  |   |   |  |  |  |   |  |   |                                   |  |
| 22b. SIGNATURE<br><u>[Signature]</u>  |  |   | DEGREE  |  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   |  | 22c. DATE SIGNED<br>2/11/82               |                                   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>J. DAVID MAGEE, MD   |  |   | 22e. ADDRESS<br>1205 York Road, Towson, Md.                               |  |  |  |   |  |   |                                   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial   |  |   | 23b. DATE<br>2/12/1982  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Holy Redeemer Cem. |  |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore, Md.   |   |                                   |  |
| 24 FUNERAL DIRECTOR<br>NAME ADDRESS<br>George J. Gonce F.H. 4001 Ritchie Hwy.   |  |   |   |  |  | 25a. DATE REC'D. BY REGISTRAR<br>FEB 11 1982   |   | 25b. REGISTRAR'S SIGNATURE<br><u>[Signature]</u>   |   |                                   |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death and be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed in the office of the Registrar after death.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  |   |                          |  |   |  |  |
|---|--|---|--|---|--------------------------|--|---|--|--|
| 1. FOR STATE REGISTRAR  |  | REG. NO.  |  |   |                          |  |   |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  |   |  |   | 2a. DATE OF DEATH        |  |   | 2b. HOUR   |  |
| CONSTANTINE ZOZOS   |  |   |  |   | FEBRUARY 1, 1982         |  |   | 4:40PM   |  |
| 3. SEX  |  | 4. RACE   |  | 5. DATE OF BIRTH  |                          | 6. AGE (IN YEARS LAST BIRTHDAY)                                  |   | 7. IF UNDER 1 YEAR   |  |
| Male  |  | White   |  | MONTH 5 DAY 21 YEAR 17  |                          | 64   |   | MONTHS DAYS HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  | 7b. CITIZEN OF WHAT COUNTRY?  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                          | 9. BALTIMORE CITY OR COUNTY OF DEATH                             |   | 10. BALTIMORE CITY MD.   |  |
| Greece  |  | Greece  |  |   |                          | BALTIMORE CITY   |   |  |  |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |   |                          | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE) |   | 12b. KIND OF BUSINESS OR INDUSTRY                              |  |
| Baltimore   |  | JOHNS HOPKINS HOSPITAL  |  |   |                          | Helper   |   | Steel  |  |
| 13a. STATE  |  |   |  |   | 13b. CITY OR TOWN        |  | 13c. STREET ADDRESS                                       |  |  |
| Maryland  |  |   |  |   | Baltimore                |  | 410 Overview Avenue                                       |  |  |
| 14. FATHER'S NAME   |  |   |  |   | 15. MOTHER'S MAIDEN NAME |  |   |  |  |
| Dimitrios   |  |   |  |   | Chrisoula Passali        |  |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)  |  |   |  |   | 16b. SOCIAL SECURITY NO. |  | 17. INFORMANT ADDRESS                                     |  |  |
| No  |  |   |  |   | 053-46-0891              |  | Mrs. Stamatina Zozos, 410 Overview Avenue, Baltimore, Md. |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Lung cancer</u><br>1629<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) _____<br>(c) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>DUE TO, OR AS A CONSEQUENCE OF     |  |   |  |   |                          |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)<br><u>Hypercalcemia</u>  |  |   |  |   |                          |  |   |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |                          | 20a. AUTOPSY?  |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |  |
|   |  |   |  |   |                          | YES <input type="checkbox"/> NO <input type="checkbox"/>         |   | YES <input type="checkbox"/> NO <input type="checkbox"/>       |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |                          |  |   |  |  |
|   |  |   |  |   |                          |  |   |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |                          |  |   |  |  |
|   |  |   |  |   |                          |  |   |  |  |
| I certify that (I) (this hospital) attended the deceased from <u>March</u> 19 <u>82</u> to <u>January</u> 19 <u>82</u> , that (I) (we) last saw the deceased alive on <u>February 1</u> 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |  |   |                          |  |   |  |  |
| 22a. SIGNATURE<br><u>Brent G. Petty</u>   |  |   |  |   |                          | DEGREE<br><u>MD</u>  |   | 22c. DATE SIGNED<br><u>1 February 1982</u>                     |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>Brent G. Petty, M.D.</u>  |  |   |  |   |                          | 22e. ADDRESS<br><u>691 N. Broadway, Balto. Md. 21205</u>         |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |  | 23b. DATE   |  | 23c. NAME OF CEMETERY OR CREMATORY  |                          | 23d. LOCATION  |   |  |  |
| Burial  |  | 2-3-82  |  | Oak Lawn Cemetery   |                          | Baltimore Baltimore Md.  |   |  |  |
| 24. FUNERAL DIRECTOR<br><u>Nicholas T. Matthews, 3021 Eastern Ave., Balto.</u>  |  |   |  |   |                          | 25a. DATE REC'D. BY REGISTRAR<br><u>FEB 4 1982</u>               |   | 25b. REGISTRAR'S SIGNATURE<br><u>James J. Matthews</u>         |  |





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed in the office of the Registrar with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

8+1

35

390

1

2

9

1

250

MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  |   |  |   |  |   |  |
|---|--|---|--|---|--|---|--|---|--|
| 1. FOR STATE REGISTRAR  |  |   |  | REG. NO.  |  |   |  |   |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>STEVE NMN ZYLKA.</b>   |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>02-22-82</b>   |  |   |  | 2b. HOUR<br><b>3:15 P.</b>  |  |
| 3. SEX<br><b>MALE</b>   |  | 4. RACE<br><b>PALESTINIAN.</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>12-24-16</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>65</b> YRS  |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MD</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY MD.</b>                                   |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>SOUTH BALTIMORE GENERAL HOSP.</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>RETIRED -&gt; FROM JAPAN</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 13e. STREET ADDRESS<br><b>1617 Cereal Street 21226</b>  |  |   |  |
| 13a. STATE<br><b>Maryland</b>   |  | 13b. COUNTY<br><b>---</b>   |  | 13c. CITY OR TOWN<br><b>Baltimore</b>   |  |   |  |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>ANTHONY Zylka</b>  |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>MARY Semenluk</b>   |  |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>YES WW II</b>   |  |   |  | 16b. SOCIAL SECURITY NO.<br><b>212-03-2430</b>  |  | 17. INFORMANT ADDRESS<br><b>HELEN ZYLKA (WIFE) 1617 CEREAL ST. BAL MD</b>                           |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>SEVERE L.V. FAILURE Sec. TO HASCVD</b><br><b>4100</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>PROBABLY MYOCARDIAL INFARCTION</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>SEVERE MYOCARDIAL DYSPLASIA</b>   |  |   |  |   |  |   |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)   |  |   |  |   |  |   |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>FEBRUARY 19, 1982</b> , to <b>FEB. 22, 1982</b> , that (I) <input checked="" type="checkbox"/> lost<br>saw the deceased alive on <b>FEB 22, 1982</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) <input checked="" type="checkbox"/> (we) <input type="checkbox"/> did (did not) view the body after death. |  |   |  |   |  |   |  |   |  |
| 22b. SIGNATURE<br><b>A. Suenas V. M.D.</b>  |  |   |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>        |  |   |  | 22c. DATE SIGNED<br><b>2-22-82</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>ANABELICA SUEÑAS V.</b>   |  |   |  | 22e. ADDRESS<br><b>3001 ST. HANOVER STREET 21230.</b>   |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY) <b>Burial</b>  |  | 23b. DATE<br><b>2/25/82</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Holy Cross Cem.</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Anne Arundel Md</b>                      |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME <b>Mc Cully F.H. of Curtis Bay</b><br><b>4200 Pennington Avenue Balto., Md. 21226</b>  |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>FEB 24 1982</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Thomas Van Natten</b>  |  |   |  |

